



**USAID** | **SENEGAL**  
FROM THE AMERICAN PEOPLE

# 2011-2016 HEALTH PROGRAM

## HEALTH SYSTEM STRENGTHENING COMPONENT: ANNUAL REPORT OCTOBER 2013 – SEPTEMBER 2014

November 2014

This report is a deliverable under contract # AID-685-A-11-00002, Health System Strengthening Component (HSS) of the USAID/Senegal Health Program, 2011-2016

The Health System Strengthening Component of the Health Program consists of technical assistance to the Government of Senegal implemented by Abt and financed by USAID under contract # AID-685-A-I I -00002

**Submitted to:** Babacar Lo  
USAID DAKAR



Abt Associates | Immeuble Abdoulaye Seck | Rue de Fatick X Bd du Sud | Point E1 Dakar  
[www.abtassociates.com](http://www.abtassociates.com)

# HEALTH SYSTEM STRENGTHENING COMPONENT: ANNUAL REPORT

OCTOBER 2013-SEPTEMBER 2014

**WARNING**

The authors' views expressed in this publication do not necessarily reflect the view of the United States Agency for International Development (USAID) or the United States Government.



# TABLE OF CONTENTS

<b>TABLE OF CONTENTS .....</b>	<b>iii</b>
<b>ABBREVIATIONS AND ACRONYMS .....</b>	<b>v</b>
<b>I PROJECT OVERVIEW .....</b>	<b>7</b>
1.1 SUMMARY .....	7
1.2 PROJECT DESCRIPTION/INTRODUCTION .....	7
<b>2 EXECUTIVE SUMMARY .....</b>	<b>9</b>
<b>3 ACHIEVEMENTS OF THE YEAR.....</b>	<b>13</b>
3.1 Achievements of sub-component A .....	13
3.1.1 Key results .....	13
3.1.2 Implementation analysis .....	21
3.1.3 Challenges, opportunities and perspectives.....	21
3.2 Achievements of sub-component B .....	21
3.2.1 Key results.....	21
3.2.2 Implementation analysis .....	26
3.2.3 Challenges, opportunities and perspectives.....	26
3.3 Achievements of sub-component C .....	27
3.3.1 Key results .....	27
3.3.2 Implementation analysis .....	30
3.3.3 Challenges, opportunities and perspectives.....	30
3.4 Achievements of sub-component D .....	30
3.4.1 Key results.....	31
3.4.2 Implementation analysis .....	34
3.4.3 Challenges, opportunities and perspectives.....	34
<b>4 CROSS-CUTTING ISSUES.....</b>	<b>36</b>
4.1 GENDER MAINSTREAMING .....	36
4.2 COMPLIANCE WITH ENVIRONMENTAL REGULATIONS .....	36
4.3 COMPLIANCE WITH FAMILY PLANNING LEGISLATION AND POLICY REQUIREMENTS.....	36
<b>5 LESSONS LEARNED.....</b>	<b>38</b>
<b>6 GUIDELINES AND PRIORITIES FOR YEAR 4 .....</b>	<b>39</b>
<b>7 MANAGEMENT AND ADMINISTRATIVE ISSUES .....</b>	<b>40</b>

<b>ATTACHMENT 1: PROGRESS ON THE ACTION PLAN/INDICATORS .....</b>	<b>43</b>
<b>ATTACHMENT 2: FINANCIAL REPORT OF the action plan of THE COMPONENT .....</b>	<b>49</b>

## ABBREVIATIONS AND ACRONYMS

<b>AAP</b>	Annual Action Plan
<b>ACA</b>	Association Conseil pour l'Action
<b>AIDS</b>	Acquired Immuno-Deficiency Syndrome
<b>ARD</b>	<i>Agence Régionale de Développement</i> / Regional Development Agency
<b>AWP</b>	Annual Work Plan
<b>BAP</b>	<i>Bureau d'Appui au Projet</i> / Project Support Office
<b>BTC</b>	Belgian Technical Cooperation
<b>CACMU</b>	<i>Cellule d'Appui à la Couverture Maladie Universelle</i> / Support bureau for Universal Health Coverage
<b>CBO</b>	Community-Based Organization
<b>CDD</b>	<i>Comité Départemental de Développement</i> / Departmental Committee for Development
<b>CDS</b>	<i>Comité départemental de suivi</i> / Departmental Monitoring Committee
<b>CONSAS</b>	National consultations on healthcare and social action
<b>COP</b>	Chief of Party
<b>CRDH</b>	<i>Centre de Recherche pour le Développement Humain</i>
<b>CRS</b>	<i>Comité régional de suivi</i> / Regional monitoring committee
<b>CTGP</b>	<i>Comité Technique de Gestion du Projet</i> / Project Management Technical Committee
<b>DAGE</b>	Department of General Administration and Equipment
<b>DF</b>	Direct financing
<b>FG</b>	Guarantee Fund
<b>DHMT</b>	District Health Management Team
<b>DLSI</b>	<i>Division de la Lutte contre le SIDA</i> / AIDS Control Division
<b>DMO</b>	Chief District Medical Officer
<b>DPPD</b>	Multi-year Expenditure Programming Document
<b>DPRS</b>	Department of Planning, Research and Statistics
<b>DSRSE</b>	<i>Direction de la Santé de Reproduction et de la Santé de l'Enfant</i> / Department of Reproductive Health and Child Health
<b>EIPS</b>	<i>Equipe d'Initiative de Politiques de Santé</i> / Health Policy Initiatives Group
<b>FHI</b>	Family Health International
<b>FNSS</b>	<i>Fonds National de la Solidarité dans la Santé</i> / National Solidarity Fund for Healthcare
<b>FY</b>	Fiscal Year
<b>HSS</b>	Health System Strengthening Component
<b>ICP</b>	<i>Infirmier Chef de Poste</i> / Chief nursing officer at health post
<b>ISSA</b>	<i>Innovations et Systèmes de Santé en Afrique</i>
<b>MHO</b>	Mutual Health Organization
<b>JPR</b>	Joint Portfolio Review
<b>MEF</b>	Ministry of Economy and Finance
<b>MIS</b>	Management Information System
<b>MNCH</b>	Maternal, Newborn and Child Health
<b>MOH</b>	Ministry of Health and Social Action
<b>MTEF</b>	Medium Term Expenditure Framework
<b>NGO</b>	Non-Governmental Organization
<b>ONAMS</b>	<i>Office national de la mutualité sociale</i> / National agency for social insurance
<b>ORCAP</b>	<i>Outil de Renforcement des Capacités par l'Auto-évaluation Participatives</i> / Capacity development tool through self-assessment

<b>PBF</b>	Performance-based financing
<b>PLWHA</b>	Person Living With HIV/AIDS
<b>PNA</b>	<i>Pharmacie Nationale d'Approvisionnement</i> / National medical store
<b>PNDS</b>	<i>Programme National de Développement Sanitaire</i> / National Health Development Program
<b>PNFBR</b>	National Program on Performance-Based Financing
<b>RH</b>	Reproductive Health
<b>RHMT</b>	Regional Health Management Team
<b>RMO</b>	Chief Regional Medical Officer
<b>SDP</b>	Service Delivery Point
<b>SRAS</b>	<i>Service régional de l'Action Sociale</i> / Regional bureau for social action
<b>TFP</b>	Technical and Financial Partner
<b>UEMOA</b>	<i>Union Economique et Monétaire Ouest Africaine</i> / West African Economic and Monetary Union
<b>URMS</b>	<i>Union Régionale des Mutuelles de Santé</i> / Regional federation of mutual health organizations
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization

# 1 PROJECT OVERVIEW

## 1.1 SUMMARY

Component name:	Health System Strengthening (HSS)
Project start date and end date:	October 1, 2011 – September 30, 2016
Name of Implementing Partner:	Abt Associates Inc.
Cooperative Agreement number:	AID-685-A-11-00002
Name of AOR:	Babacar Lo
Name of Subcontractors or Consortium members:	Groupe Innovations et Systèmes de Santé en Afrique (Group ISSA) – Association Conseil pour l’Action (ACA) – Centre de Recherche pour le Développement Humain (CRDH) – Family Health International (FHI360) – PATH – Broad Branch Associates
Geographic coverage (per region)	Kolda - Sédhiou - Ziguinchor - Louga - Thiès - Diourbel - Kaolack - Kaffrine - Fatick - Dakar (Departments of Pikine and Rufisque only)
Reporting period:	October 2013-September 2014

## 1.2 PROJECT DESCRIPTION/INTRODUCTION

The Health System Strengthening (HSS) Component is one of five assistance instruments of USAID/Senegal’s 2011-2016 Health Program. The development objective of the Program is an “improved health status of the Senegalese population” and is to be reached through three intermediate results (IR): “Increased use of an integrated package of quality health services” (IR 1); “Improved health seeking and healthy behaviors” (IR 2); and “Improved performance of the health system” (IR 3). The Health System Strengthening Component contributes to achieving these intermediate results in collaboration with four other components of the USAID/Senegal Health Program: (i) health services improvement, (ii) HIV/AIDS and Tuberculosis, (iii) community health, and (iv) health communication and promotion.

The main objective of the HSS Component is to improve the performance of the decentralized (regional and district levels) public health system supported by effective and efficient policies, planning and budgeting at the central level of the Ministry of Health. The HSS Component will contribute specifically to the realization of Intermediate Result 3 through “an improved management of district and regional health teams” (IR 3.1) and an “improved health system performance through development and implementation of national level policies” (IR 3.2).

The HSS Component is divided into four sub-components focusing on key areas for improving health system performance. The “Management and health systems at regional and district levels” sub-component will contribute to improving the effectiveness and quality of healthcare service delivery through improved health governance at the local level, enhanced capacities of regional and health district management teams, and motivation of staff working at health huts, posts and centers to extend the reach of priority healthcare services supported by performance-based financing (PBF) mechanisms. The “Social financing mechanisms” sub-component will focus on improving access to healthcare for populations in general and vulnerable groups in particular, by reducing financial barriers to healthcare and expanding health coverage through

mutual health insurance schemes and the support of government authorities. Finally, sustainable improvements in health system performance will be ensured with the creation of an enabling environment to support policy development, enhanced resource allocation for the sector, synergy and alignment of interventions with PNDS 2009-2018 priorities through the sub-components “Policies and reforms” and “Coordination of the Health Program”.

The Component intervenes at different levels of the health system. The sub-component “Policies and reforms” focuses on policy dialogue at the central level. The sub-components “Management and health systems at the regional and district levels” and “Social financing mechanisms” intervene at the central, technical and operational levels and activities are conducted in the Dakar (Departments of Pikine and Rufisque only), Diourbel, Fatick, Kaffrine, Kaolack, Kolda, Louga, Sédhiou, Thiès and Ziguinchor regions. The sub-component “Coordination” intervenes at the level of the USAID Health Program.

USAID/Senegal signed a cooperative agreement with Abt Associates to serve as implementing agency of the HSS Component. Abt Associates put up a multi-disciplinary team of Senegalese experts, Senegalese organizations and international sub-contractors with longstanding and valuable experience to implement the HSS Component. In addition to Abt Associates, the HSS team comprises Groupe Innovations et Systèmes de Santé en Afrique (Group ISSA), Association Conseil pour l’Action (ACA), Centre de Recherche pour le Développement Humain (CRDH), Family Health International (FHI), PATH and Broad Branch Associates.

The annual action plan for Year 3 of the HSS Component (October 2013 to September 2014) was developed with a view to seizing opportunities offered by recent policy changes in the health sector to improve health system performance by focusing on the practical application of planning, implementation, management and financing instruments developed during the first two years. Based on these general guidelines, the following priorities defined by the USAID Health team facilitated the development of the 2013-2014 action plan:

- Nutrition activities
- Implementation of the family planning action plan
- PBF implementation and coordination with the World Bank program
- Supply chain management support
- Support to family planning, maternal health and child health interventions with proven results/impact
- Support to implement universal health coverage
- Implementation of direct financing activities
- Coordination of activities of regional bureaus and integrated work plans

The annual report is divided into seven (7) sections. The first section provides an overview of the HSS Component and the second presents a summary of key results and challenges of Year 3. Section three summarizes accomplishments of Year 3 per sub-component while section four discusses how cross-cutting issues are addressed during implementation of interventions. Section five recaps lessons learned in Year 3 and section six identifies orientations and priorities for Year 4 of the Program. The seventh section summarizes the financial implementation of the Component’s budget. The annual report is supplemented by two attachments: Attachment 1 summarizes the Component’s financial report and Attachment 2 presents the PMP indicators of the Component.

## 2 EXECUTIVE SUMMARY

---

- **Key results**

The Component's key results achieved in Year 3, contributing to the attainment of the USAID Health Program's intermediate results, are summarized below: "Improved management of district and regional health teams" (Intermediate Result 3.1); "Improved health system performance through development and implementation of national level policies" (Intermediate Result 3.2).

### **Intermediate Result 3.1 (IR3.1): Improved management of district and regional health teams.**

The HSS Component advanced during Year 3 towards attaining IR3.1 of the USAID/Senegal's results framework through accomplishments in enhancing health system governance at the local level, strengthening capacities in planning, management and monitoring of health interventions, and implementing new direct financing and performance-based financing instruments to improve performances of health service managers and health workers at health centers and health posts.

**Health governance.** For improved governance of the health system by actors who fully play their roles at regional and health district levels, good governance indicators were presented at coordination meetings of districts and regions. Forums for consultation among stakeholders in the healthcare sector were organized in Kaffrine and Kaolack during the 2<sup>nd</sup> quarter.

**Capacities in planning, management and monitoring.** There were several accomplishments in Year 3 as part of efforts to strengthen capacities of medical regions and health districts in planning, management and monitoring of healthcare interventions. A total of 177 RHMT and DHMT members were trained on how to utilize the ORCAP tool in eight (8) medical regions. In addition, 251 RHMT/DHMT members were trained on developing health-related POCLs. Support was provided in the Dakar, Diourbel and Sédhiou regions during the second quarter to assess 2013 AWP. All local government units in regions under direct financing prepared their health-related POCLs and all health districts/medical regions in the Component's focus regions were provided support to prepare their 2014 and 2015 AWP. Support was further provided for the organization of JPRs, quarterly coordination meetings and supervision visits in all medical regions in the intervention zone with the exception of Louga. Computerization of the financial management system of medical regions and health districts was commenced during the 2<sup>nd</sup> quarter. The 2013 financial reports of Thiès and Kaolack were prepared during the 2<sup>nd</sup> quarter. Lastly, 146 staff members of health districts/medical regions and 35 employees of MOH central services were trained on stock accounting.

**Direct financing.** The Direct Financing (DF) initiative was extended to the three (3) regions of Diourbel, Sédhiou and Ziguinchor during Year 3 following the successful pilot experience in the Thiès Kaolack and Kolda regions in Year 2. Preparation and signing of 2014 implementation letters (ILs) with the regions of Diourbel, Kaolack, Kolda, Sédhiou, Thiès and Ziguinchor was delayed as a result of demands by some agencies to secure the inclusion of specific activities of their components in the activities covered through direct financing. ILs were finally signed in June. Consultations held with stakeholders led to an amendment of ILs in order to minimize the consequences of the late signing of 2014 ILs and facilitate validation of milestones by regional validation committees. Milestones for the first quarter of 2014 in the six regions were validated and paid. Milestones for the second quarter of 2014 were also validated in the Kaolack, Thiès and Sédhiou regions.

**Performance-based financing.** The Performance-Based Financing (PBF) initiative was strengthened in pilot regions to enhance coverage and quality of priority healthcare services (maternal health, family planning, child health, combating malaria, tuberculosis and HIV). The steering committee meeting and the second PBF national review were held during the 2<sup>nd</sup> quarter and PBF indicators were later revised. PBF bonuses under

phase II of the project were effectively paid in the seven districts within the Kaffrine and Kolda regions. Furthermore, 127 PBF contracts were signed with beneficiaries in the two regions for the year 2014. Documentation of the PBF initiative was further reinforced with the production of the semi-annual report on PBF documentation and evaluation of the PBF design and implementation process: the evaluation report of the PBF process is currently being prepared. Moreover, PBF beneficiaries were provided guidance on USAID requirements in the area of FP. They are also currently attending training on the 5S approach to enhance the quality of services. Lastly, the Component took part in the validation workshop of the World Bank-USAID project's procedures manual.

**Intermediate Result 3.2 (IR 3.2): Improved health system performance through development and implementation of national level policies.**

The HSS Component progressed towards achieving IR 3.2 of USAID/Senegal's results framework through accomplishments under the following three sub-components: (i) Social financing mechanisms, (ii) health policies and reforms, and (iii) coordination of the USAID/Senegal Health Program.

***Social financing mechanisms.*** The HSS component continued its support at the strategic level to improve access to healthcare services and financial protection of populations in terms of healthcare, foster policy dialogue and establish MHO networks at the operational level. The Component continues to provide assistance to the MOH for the establishment of a regulatory and institutional support framework for UHC. The UHC program was hence launched at the national, regional and departmental levels (official launch, CRD, CDD) with the support of the Component. The Component helped organize a study tour to Ghana in October 2013 for a delegation comprising representatives of the MOH, MEF, National Assembly and locally-elected officials to share experiences of the national health insurance support system. Furthermore, the Component supported the organization of three (3) interministerial council meetings on the UHC strategic development plan, establishment of the UHC national interministerial steering committee and drafting of a UHC law in Senegal.

The Component also helped put in place financing mechanisms to channel subsidies for expansion of MHO benefits packages and to provide health coverage for the poor through MHOs. Government subsidies to MHOs have been in effect since the 2<sup>nd</sup> quarter and delivered to 75 MHOs, financing agreements between the MOH and regional MHO federations were signed, as well as agreements between regional MHO federations and MHOs under the chairmanship of governors of regions. Targeted subsidies for the poor through MHOs are effective for 5 956 indigents in the Diourbel, Fatick, Kaffrine and Kaolack regions.

At the technical level, the Component provided support for the production of tools to help strengthen the technical capacities of stakeholders. A training manual on setting up an MHO was developed. The Component also provided support for the training of 130 regional trainers, including a group of trainers in each of the 14 regions nationwide. It supported the development of an MHO management procedures manual and a training manual on administrative and financial management of MHOs. Lastly, it supported the development of a manual on the management of free healthcare initiatives.

At the operational level, the Component provided support to extend UHC by establishing the DECAM project in ten (10) demonstration departments. It continued to provide assistance for the setting-up/restructuring of 49 MHOs and 3 departmental federations in the first three demonstration departments of Kolda, Louga and Kaolack. It initiated the establishment of 78 new MHOs and the restructuring of 41 MHOs in the seven new demonstration departments of Rufisque, Mbacké, Mbour, Fatick, Kaffrine, Goudomp and Ziguinchor. Of the 119 initiatives launched, 101 have already held their constitutive or restructuring general assembly meetings: 15 in Rufisque, 26 in Mbour, 29 in Mbacké, 12 in Goudomp, 4 in Ziguinchor, 5 in Kaffrine and 10 in Fatick. A total of 2,412 MHO action committee members were trained in Year 3. Also, a total of 323 MHO administrators and managers were trained on administrative and financial management.

Moreover, all MHOs outside of the DECAM project zone received direct support for the organization of ordinary general assembly meetings, planning workshops and awareness-raising campaigns to expand their

membership base. MHOs in intervention regions had a total of 299,457 beneficiaries by the end of the year. The trend is downward in comparison to the previous year because some MHOs cleaned up their client database. However, new MHOs have commenced enrolment and the number of beneficiaries will increase.

With regard to vulnerable groups, only 7,908 people had health coverage this year through MHOs with the support of a third party because NGOs such as Worldvision discontinued grants for providing health insurance to school children and vulnerable persons. Among poor people with health coverage, 5,956 benefitted from Government subsidies.

Furthermore, all ten (10) regional federations in the project's intervention zone were supported for the organization of statutory meetings as well as to conduct monitoring activities, advisory support and identification of MHO needs, particularly those experiencing operational difficulties. They were also involved in the development of management procedures manuals and benefitted from close supervision for the utilization of government subsidies in compliance with the principles of sound management of public resources. The Component provided technical and financial assistance for the establishment of a national federation of community-based MHOs that will serve as a support platform for dialogue and representation at the country level.

The Component continued its support to reinforce the project on providing healthcare to PLWHA in Kaolack and its extension to the Ziguinchor and Kolda regions. Thus, at the country level, the working group comprising representatives of leading partners (DLSI, DAMS, CACMU, Abt and FHI) finalized the development of the PLWHA project's operations manual. The regional bureaus of Kaolack and Kolda participated in workshops to discuss the project's operations manual during which major barriers to its application, in light of the CMV+'s action plan, were identified and solutions proposed. Other meetings of the select national committee discussed issues relating to the coordination, management and strategic monitoring mechanism of the PLWHA project. Furthermore, technical support and supervision of regional committees by the CNP continued to be provided at a distance or during field visits especially to new sites in the southern part of the country. A total of 316 beneficiaries have been enrolled between January 2011 and December 2013 and 260 are currently covered.

**Policies and reforms.** The HSS Component contributes to strengthening capacities in developing and implementing health reform policies. It provided support for the development and validation of the community health strategic plan in collaboration with the PSSC Component. The community health strategic plan centers on five strategic areas as follows: improving the geographical spread of community-based facilities; ensuring deeper integration of community health with the health system; improving the quality and broadening the healthcare service base at the community level; increasing the participation of communities and local government units in community healthcare management; and establishing a governance system and an implementing strategy.

It provided support for the development and validation of the National Medical Store's (PNA) strategic plan and continues to help improve the latter's information and management system. The general objective of the strategic plan is to ensure availability and affordability of drugs and essential products for populations. Specific objectives focus on: reducing processing time of procurement actions; improving the quantification of needs; reducing processing time of client orders; ensuring availability of a distribution chain at the peripheral level; improving stock management; ensuring existence of a central purchasing body and PRAs that comply with storage and safety norms; optimizing resource management; and reinforcing the price equalization system by creating a balance between resources and expenditures.

It contributed to initiating the development of the policy paper on traditional medicine. The Component provided support for the conduct of the PNLP organizational audit. It also helped produce a policy paper on health district reform. It contributed to the finalization of the terms of reference for the revision of the health map. In the context of FP advocacy, two consultants were recruited by the Component to help develop the FP advocacy plan. Moreover, it provided support for preparation of an evaluation report on the financial commitments of PANPF and assisted in the organization of three (3) special CRD meetings on FP in

the Sédhiou, Kaolack and Kaffrine regions. As part of activities to monitor implementation of the PNDS, the Component provided assistance for preparation of the 2015-2017 preliminary DPPD and the 2013 health sector MTEF performance report. It also assisted in the preparation of the MOH's 2013 annual financial report and 2014 quarterly financial reports (Q1 and Q2). These reports served as working documents for the PNDS joint portfolio review.

**Coordination.** Coordination of interventions of the USAID Health Program was enhanced with the development of the second integrated action plan of the health program (2014 IAP). The Component organized a retreat to further improve monitoring of performance-based financing activities, direct financing and the DECAM initiative. Weekly planning and activity monitoring meetings were organized at regional bureaus to ensure enhanced coordination for implementation of the Health Program's interventions at regional and local levels. Regional bureaus also organized quarterly coordination meetings with medical regions throughout the intervention regions. Finally, the Component's database continued to be updated and an audit on MHO data quality was performed. The Component prepared the annual report and fourth quarter report for Year 2 as well as quarterly reports for Year 3.

- **Key challenges**

Several challenges relating to new reform initiatives were faced in Year 3 during implementation of the HSS Component. However, some of these challenges have already begun to be addressed.

Faced with the challenge of weak capacities in planning, management and monitoring at the operational level, the Component provided the MOH with support, through DPRS and DAGE, to develop planning and management tools and train stakeholders at the central and operational levels. The ORCAP tool was hence completely overhauled and adapted to the realities of districts, and employees of MOH central services as well as RHMT and DHMT members in the Component's intervention zone were trained. 2014 ORCAP action plans were developed in eight (08) medical regions. The administrative management guide and stock accounting tools were developed and users trained. Development of a computerized financial management system for medical regions and health districts is currently on-going with the support of the HSS Component.

With the challenge of improving the implementation and monitoring process, a quick review of Direct Financing (DF) was performed at the end of the first year and findings analyzed prior to its extension to three other regions. The Component provided support to develop harmonized tools for monitoring DF implementation and preparation of the annual financial report on direct financing. Also, the Ministry of Health put in place a Steering Committee in charge of monitoring DF implementation, chaired by the Secretary General.

Delays in mobilizing MHO subsidies were a major constraint for UHC implementation in the pilot departments of Louga, Kaolack and Kolda. This constraint was however addressed with the effective mobilization of subsidies during the second quarter of Year 3. Nonetheless, the delay in implementing the UHC communication plan remains a challenge.

The sub-component "policies and reforms" was faced with two major constraints during Year 3, namely, delays in the signing of the decree on the reorganization of the MOH and introduction of the DPPD. The decree will facilitate a clear identification of support areas for an optimal operation of structures, particularly newly established ones. With the introduction of the DPPD, all support directed towards strengthening the health sector MTEF process has been put on hold pending more specific guidelines on changes to be effected and the new distribution of roles and responsibilities within the MOH.

## 3 ACHIEVEMENTS OF THE YEAR

---

### 3.1 Achievements of sub-component A

#### 3.1.1 Key results

- **GOVERNANCE AND LEADERSHIP**

Achievements of Year 3 in the area of governance and leadership relate primarily to the organization of consultation platforms attended by health sector stakeholders, and the collection, processing and presentation of data on good health governance indicators. Of the four regions that received support in Year 2 from the Component for the establishment of consultation frameworks, the Kaffrine and Kaolack regions effectively organized periodic meetings. Status of implementation of activities in their respective action plans was discussed and strategies for improvement proposed.

The three regional bureaus provided support for presentation of good governance indicators for 2013 during coordination meetings of health districts and medical regions in intervention zones covered by the Component. The fourteen (14) indicators of good governance in the health sector at the local level include the following four domains: improvement of the planning system, coordination, monitoring and evaluation (7 indicators); improvement of resource management mechanisms (4 indicators); strengthening multisectorial relations and partnerships (1 indicator); functionality of frameworks of community participation in the management of health facilities (2 indicators). During the last quarter of Year 3, DHMTs and RHMTs collected and analyzed data on good governance indicators for 2014 in all intervention regions except Diourbel where this activity is scheduled for next quarter.

- **CAPACITIES OF MEDICAL REGIONS AND HEALTH DISTRICTS IN PLANNING, MANAGEMENT AND MONITORING**

**ORCAP implementation.** Pursuant to the presentation of the report and results achieved in Year 2, the DPRS expressed its interest for continued use of the ORCAP tool in the Ministry of Health's planning process. This year, the HSS Component hence supported the training of twenty seven (27) staff members of the DPRS and other MOH departments on the ORCAP tool primarily to ensure a training of trainers who will contribute to a more rapid roll-out of the tool in the 10 regions targeted in 2014. A total of 204 RHMT and DHMT members from eight (08) medical regions participated in this training with the exception of the Kolda and Louga regions. Hence, performances of these responsibility centers were assessed based on the six Service Delivery Areas (SDAs) and an action plan developed to address gaps identified. Using resources earmarked for the development of the 2014 ORCAP plan, the Kaolack medical region was able to plan, during the fourth quarter, ORCAP activities for 2015 based on the 2015 AWP approved in June in accordance with new UMOA guidelines on the DPPD.

The tool was also completely overhauled and adapted to the realities of districts during workshops to develop the 2014 ORCAP plans in the districts of Nioro, Thiès and Bignona. Members of health management teams and ICPs showed great interest in this tool as a means to enhance the health system. One hundred and two (102) staff members participated in these workshops in the three districts.

**Support for the development of 2015 POCLs.** Regional bureaus of the Health Program, in collaboration with an MOH/DPRS team, provided support for the organization of orientation sessions on the POCL development process for RHMTs, DHMTs and other partners of medical regions and health districts. These sessions were organized during the 1<sup>st</sup> and 3<sup>rd</sup> quarters of Year 3 with a view to developing 2014 and 2015 AWP. The objectives of this activity were to: (i) discuss the formulation process of health POCLs, (ii) provide information on the role and responsibilities of local government units in the health

sector's local planning process, (iii) understand the methodological approach for determining health issues and identify activities to be implemented, and (iv) share templates for developing POCLs. The approach used to develop 2015 health POCLs was to roll-over, on the basis of the on-going assessment of 2014 POCLs, routine activities of health committees as well as investments planned in 2015 by the Government, development partners and local government units.

**Development and monitoring of AWP in medical regions and health districts.** During the first quarter of Year 3, RHMTs and DHMTs in the Thiès and Dakar regions attended refresher training sessions on the AWP management guide, with the support of the Thiès regional bureau. This year, the HSS Component provided technical and financial support for the development, validation and consolidation of 2014 and 2015 AWP of medical regions and health districts in its intervention zone.

Each quarter, regional bureaus provided assistance for the organization of regional workshops to monitor implementation of 2014 AWP. During these workshops, performances in implementing AWP were discussed on the basis of output indicators, the implementation level of AWP activities assessed, implemented activities that were not included in AWP presented, constraints identified and activities for the next quarter planned. Support was previously provided to organize evaluation workshops of 2013 AWP in the Dakar, Diourbel and Sédhiou regions. The various responsibility centers presented their achievements of 2013, constraints and difficulties encountered and prospects for 2014.

**Annual joint reviews and regional coordination meetings.** All regions in the intervention zone received support for the organization of their Joint Portfolio Review (JPR) except the Region of Louga, which received assistance from another partner. These reviews were an opportunity to assess the degree to which performance indicators were met and recommendations made to improve these indicators. The HSS Component provided support for the organization of quarterly coordination meetings of medical regions and monthly meetings in health districts except in the Louga region. Implementation of certain programs was discussed during these meetings and AWP of the various responsibility centers monitored.

**Support for the supervision of health districts by RHMTs.** Medical regions in the HSS Component's intervention zone received financial and technical support from regional bureaus for the organization of supervision missions to districts. The level of performance in implementing activities relating to UHC, malaria control, management of the Ebola outbreak, verification of tools for collecting data and report writing as well as the filing system in place were assessed during this activity. As part DF implementation, MOH priority programs were monitored in districts and SDPs under DF by RHMTs and DHMTs.

Under the line of action “**Enhancing the financial management capacities of regional and district management teams**”, the HSS Component, through ACA, continued to provide support during Year 3. The training guide on administrative management currently being developed was not finalized as a result of delays in the MOH reorganization process. However, many activities were conducted as part of efforts to strengthen management capacities of medical regions and health districts:

- *Training on stock accounting in medical regions and health districts.* In addition to the Kaolack, Kolda and Thiès regions where training on stock accounting was conducted in Year 2, all other regions were trained this year. A total of one hundred and ninety five (195) health district/medical region employees and 35 staff of MOH central services were trained on stock accounting. These sessions were moderated by management advisers at regional bureaus in collaboration with the DMTA of the Ministry of Finance and the DAGE/MOH stock manager. Capacities of medical regions and health districts in the management of assets belonging to the central Government, local governments and public institutions were strengthened. Training centered on: (i) the study of regulations governing stock accounting, (ii) the role of various actors involved in assets management, (iii) application of different assets management tools, and (iv) the development of an action plan to enhance assets management. In addition to training stock managers, the workshops were also an opportunity to provide guidance to hospital directors, DMOs and heads of departments.

- *Monitoring financial management and stock accounting activities in medical regions and health districts.* During the first quarter, meetings were organized in collaboration with DAGE/MOH to assess financial management and stock accounting procedures of medical regions and health districts and to incorporate the financial management system into the procedures manual being developed by DAGE/MOH. These meetings helped identify major shortcomings regarding accounting and financial management (irregular filling of documents, insufficient materials for filing and archiving documents, insufficient computer materials, plurality of management tools proposed by financial and technical partners, turnover of already trained managers). During Year 3, administrative and financial management advisers at regional bureaus provided support to medical regions and health districts in their financial management monitoring activities. Supervision visits were hence conducted to help medical regions and health districts put in place management tools. Management advisers helped managers correctly record financial transactions relating to 2013 DF activities. Monitoring of stock accounting systems was continued with the support of the Component. Managers of responsibility centers in regions finalized the inventory lists of each service and established baseline situations on stock accounting for each responsibility center.
- *Development of an accounting software for medical regions and health districts.* The accounting tools used to train ten administrators from medical regions were integrated into Excel. These tools were previously used manually. Linkages between these tools will help generate information on available resources, expenditures and rate of implementation on a monthly or quarterly basis. However, in order to boost system performance, it was considered more appropriate to use ACCESS. Design of a computerized financial management system for medical regions and health districts is currently on-going based on observations and recommendations made on the first version of the software developed by the consultant.

**Preparation of annual financial reports.** 2013 milestones for the Thiès, Kaolack and Kolda regions were paid this year. The 2013 annual financial report of the Kaolack medical region was prepared with the support of the Kaolack regional bureau. Reports of the Thiès and Kolda regions are currently being prepared.

- **DIRECT FINANCING IMPLEMENTATION.**

Key activities conducted during the first two quarters led to the payment of milestones for 2013. In January 2014, the Component organized a review of DF implementation, analyzing results achieved and drawing the necessary conclusions to enhance implementation and monitoring of the process. Six (6) medical regions benefitted from the direct financing initiative in 2014: Thiès, Kaolack, Kolda, Ziguinchor, Sédhiou and Diourbel. All six regions took part in this review and the opportunity was seized to conduct negotiations on milestones and activities for 2014. The late signing of contracts as well as observations and reservations of certain agencies delayed the execution of 2014 implementation letters. This delay resulted in an overlap between deliverables of the 1<sup>st</sup> and 2<sup>nd</sup> quarters. A workshop was hence organized in July 2014 to revise 2014 DF deliverables with the participation of medical regions, coordinators of regional bureaus and representatives of CRVs. It provided an opportunity to review implementation of activities during the first half of 2014 in the six beneficiary regions. Difficulties encountered were identified and solutions proposed (see box A1).

#### **Box A1: Amendment of Direct Financing 2014 Implementation Letters**

The delay in signing direct financing implementation letters for 2014 by the Health Program's Cooperating Agencies affected the physical and financial execution of annual work plans of beneficiary medical regions and health districts. Included among the consequences are the following :

- Delays in the mobilization of financial resources for the milestones of the 1<sup>st</sup> and 2<sup>nd</sup> quarters;
- Late inclusion of community-based activities after the stabilization of DF AWP; non-involvement of all actors in the negotiation of eligible activities;

- Integrated outreach activities not implemented entirely in a few regions such as Kaolack;
- Costs of certain activities (training, purchasing with CBO) which limited their pre-financing by HDs;
- Unavailability of funds limited regions capacities to implement activities with a large budget.

First generation beneficiary regions were able to partially cover the subsequent shortfall with residual funds from the last direct financing payments made in 2013. Some health districts were able to implement their quarterly work plans and achieve high completion rates through pre-financing afforded by health committees based on the belief that health districts would soon receive USAID direct financing payments. Consequently, amendments were made to implementation letters thus enabling medical regions and health districts to address risks associated with the late signing of direct financing implementation letters for 2014.

Drafting of amendments to implementation letters was conducted in four stages: Firstly, the following guiding principles were established during a preparatory meeting to draft amendments: (i) minimize the impact that the delay in the signing of implementation letters has on completion rates of AWP of beneficiary regions; (ii) show flexibility in the renegotiation of schedules and deliverables; (iii) ensure compliance with budget limits of implementation letters; (iv) adhere to the contract performance period; (v) ensure compliance with payment deadlines. Secondly, the three regional bureaus of the Health Program organized missions to monitor direct financing activities in collaboration with beneficiary medical regions. A review of DF implementation in beneficiary regions was conducted during these missions to provide a baseline for revising the schedule of deliverables. Reports on reviews conducted in each of the six beneficiary regions served as working documents during the workshop on the revision of deliverables. Thirdly, an inter-agency meeting of COPs, with participation extended to members of the direct financing monitoring committee, was held on Tuesday July 8, 2014 at the Abt offices to finalize preparations for the workshop on the revision of direct financing deliverables. During this meeting, status of payment requests for the first direct financing milestone was reviewed. The meeting then focused on reviewing and validating the terms of reference of the workshop on the revision of direct financing deliverables planned from July 14 to 16, 2014. Finally, a workshop to revise direct financing deliverables was effectively held from July 14 to 16, 2014. The workshop was attended by chief regional medical officers of the six beneficiary medical regions, representatives of regional verification committees (CRV), representatives of the Health Program's regional bureaus, representatives of the Health Program's Cooperating Agencies, representatives of the DAGE and DPRS and a representative of USAID. Workshop proceedings determined, for each medical region: (i) 2<sup>nd</sup> quarter deliverables to be verified by the CRV in July 2014; (ii) 2<sup>nd</sup> quarter deliverables to be transferred to the 3<sup>rd</sup> or 4<sup>th</sup> quarter as a result of the delay in the signing of direct financing implementation letters.

The conclusions of the workshop served as a basis for amendment of direct financing 2014 implementation letters of beneficiary regions. Signing of amended implementation letters by cooperating agencies and medical regions was facilitated by the participatory approach used during the drafting of amendments and the participation of stakeholders in the different stages of the process.

Supervision missions were conducted by CRVs with regard to 2014 first quarter milestones and responsibility centers in DF regions received their payments. For the second quarter, only three (3) of the six (6) regions, i.e. Kaolack, Thiès and Sédhiou, have to date held their CRV meetings under the chairmanship of their respective governors and received wire transfers from agencies in payment of milestones reached, after validation of deliverables.

Furthermore, the Ministry of Health put in place this August, a Steering Committee in charge of monitoring DF implementation, chaired by the Secretary General. A meeting of this committee provided an opportunity to assess results obtained, share lessons learned and put forward recommendations to enhance DF implementation in the regions as well as FARAs of MOH programs and central departments. It shall also be noted that the Component provides support to ensure a proper functioning of CRGs and the organization of quarterly meetings to monitor DF implementation.

#### • **PERFORMANCE-BASED FINANCING MECHANISMS**

The Component continued its "Support to implement PBF" through several activities in the Kaffrine and Kolda regions:

**Missions to supervise beneficiaries in the five (05) new districts.** During the first quarter, the HSS Component strengthened the capacities of beneficiaries in the five extension districts to effectively utilize data collection tools. These include quarterly performance reports, healthcare quality checklists and payment requests. Supervision missions comprising members of the PBF National Program, RHMT and DHMT members concerned and Abt advisers were hence organized. Missions were continued during the 2<sup>nd</sup> quarter in the health districts of Kolda and Vélingara and made it possible to assess PBF implementation, help beneficiaries find solutions to difficulties encountered, develop action plans to address these issues and correctly utilize PBF data collection tools.

Furthermore, the Kaolack regional bureau provided support for the organization of an orientation workshop in Malem Hodar for locally-elected officials, health committee members and assistants of local councilors on the PBF project and cycle and on the roles and responsibilities of the various actors involved in PBF implementation.

**Independent verification system.** The Component provided support to the MOH for the organization of three verification missions in Year 3. Third and fourth quarter data for 2013 and first quarter data for 2014 were verified in health districts within the Kaffrine and Kolda regions. Following familiarization with the terms of reference prepared by the National Program, the CRG of Kolda visited the four districts of the Kaffrine region to conduct a verification of data covering the relevant quarter in all health centers, the DHMT and 30% of selected health posts, while the CRG of Kaffrine conducted the same exercise in the three districts of the Kolda region. The list of households to be surveyed was prepared by the verification team for each indicator and submitted to CBOs in charge of conducting the survey, through the CRG chairperson. Findings of the verification mission were shared with providers in the presence of health committee members. Difficulties observed included the lack of training of CRG members on new indicators introduced during implementation Year 3, a breakdown in information systems of facilities (logbooks missing or incorrectly filled out, lack of a filing system...).

Subsequent to the household survey conducted by CBOs, CRGs organized workshops to reconcile quarterly data, with the support of the Component. Analysis of documents used during this reconciliation exercise reveals that health facilities still have inadequacies in terms of preparing performance reports and payment requests, and that reports submitted by verification missions lack precise arguments and explanations, which sometimes makes decision-making difficult during the data validation phase.

Beforehand, the selected CBO, Pencum Bambouck of Kounghoul, was trained on PBF definitions and concepts, on household survey techniques in the context of the PBF pilot project, data verification and utilization of verification tools and materials. This training was followed by a refresher training session in Kaolack for members of all CBOs in the Kaffrine and Kolda regions. Difficulties being encountered during surveys were discussed as well as modifications to the questionnaire and expectations of the national PBF program for the current year.

**Support to implement activities of the PBF steering committee.** Assistance was also provided during the 2<sup>nd</sup> quarter for the conduct of the semi-annual meeting of the Steering Committee and the second national review of the PBF pilot project. The Steering Committee meeting held in January 2014 was an opportunity for members to measure progress made by the project by reviewing activities conducted since March 2013, the project's financial execution, strengths, weaknesses and prospects.

Members of the Steering Committee as well as other PBF stakeholders, particularly at the regional level, were in high attendance at the second national review organized on January 30 and 31. During this review, which covered the period from January to September 2013, (i) the state of implementation of recommendations adopted at the previous review was discussed, (ii) progress made in project implementation reviewed, (iii) difficulties encountered identified, and (iv) measures proposed to enhance project implementation. During discussions and break-out sessions, emphasis was laid on actions to be undertaken to address issues relating to the information feedback system, particularly failure to observe

deadlines for transmitting healthcare information as well as payment of PBF bonuses. Other issues such as the lack of adequate human resources, absence of accompanying measures, revision of PBF budgets taking into consideration the specificities of each zone and motivation of CRG members were also discussed.

Pursuant to the recommendations of the review, a workshop was organized to revise PBF indicators and was attended by members of the PBF national program, representatives of various central-level departments, services and programs, the RMOs of six regions, hospital directors, representatives of beneficiaries and TFPs. Indicators and quality checklists of health posts and centers were revised and indicators for EPS I and 2 validated. The PBF national program took advantage of the presence of relevant stakeholders to randomly select, with the support of the World Bank, recipient districts and control districts for assessing impact in the four new PBF extension regions (Kédougou, Sédiou, Tambacounda and Ziguinchor).

<b>PBF: HP and HC benchmarks for performance measurement</b>	
<b>Indicator</b>	<b>Weight (%)</b>
<i>A) Maternal, newborn and child health (MNCH)</i>	
1. Rate of complete vaccination coverage of infants under one year of age*	9
2. Rate of SNP coverage of children under two years of age**	6
3. Proportion of children aged 6 to 59 months that have effectively received vitamin A* supplements during routine checks	6
4. Rate of skilled attendance at birth**	12
5. Rate of new users of family planning services*	12
6. Rate of utilization in post-natal consultation*	8
7. Rate of pregnant women attending pre-natal consultation who have been tested for HIV**	6
8. PNC completion rate (adequate coverage)*	6
9. Proportion of newborns that received immediate care**	5
10. Percentage of children aged 0 to 5 years suffering from severe acute malnutrition (without other complications) that have been correctly treated**	
11. Proportion of children aged less than 5 years suffering from complicated severe acute malnutrition that have been treated and discharged ***	4
12. Rate of skilled attendance at birth with the use of a partogram***	11
13. Proportion of obstetrical complications treated in compliance with norms and protocols***	6
14. Proportion of pregnant HIV-positive women under ARV treatment***	4
15. Proportion of children, born of an HIV-positive mother, under ARV treatment for prophylactic purposes***	5
<i>B) Disease control</i>	
1. IPT2 coverage rate for pregnant women*	10
2. Percentage of children under 5 years of age suffering from uncomplicated malaria who have been successfully treated**	6
3. Percentage of children under 5 years of age suffering from uncomplicated diarrhea who have been successfully treated**	7
4. Tuberculosis detection rate***	10
5. Rate of tuberculosis cases successfully treated***	12
Note: * indicators for HPs and HCs; ** indicators for HPs; *** indicators for HCs	

**Renewal of performance contracts for 2014.** During the third quarter of Year 3, the Component assisted each district in the organization of a workshop to renew performance contracts for 2014. Prior to this, PBF indicators of health posts and health centers were revised with the introduction of new nutrition-related indicators for which baseline situations had been established by DHMTs and shared with beneficiaries. Thus, for each district, the baseline situation was validated, beneficiaries briefed on USAID FP requirements, annual indicator targets determined and PBF budgets estimated based on the updated staff list in beneficiary facilities. The EPS' of Kaffrine and Kolda signed their performance contracts in August 2014. PBF performance indicators for EPS' were validated, baseline situations established and personnel briefed on the definition of PBF, related concepts and the PBF cycle. A total of **one hundred and twenty seven**

(127) **performance contracts** were signed including two with hospitals and two with RHMTs recently enrolled in the PBF process.

**Support for assessment of the PBF process.** The HSS Component, in collaboration with Abt/Associates headquarters, provided support to conduct an assessment of the PBF process. As well as visiting Senegal, the team from headquarters also worked with CRDH to compile, record and analyze quantitative data from PNFBR. With regard to qualitative data, interview guides were prepared and validated by PNFBR. They were then tested prior to being utilized for the main qualitative survey in the Kolda, Molem Hodar and Médina Yoro Foulah districts. Key results are available and were shared with PNFBR and later presented at the 3<sup>rd</sup> Global Symposium on Health Systems Research (HSR Symposium) held in October 2014 in Cape Town, South Africa (see Box A2). The report is being finalized and after dissemination will serve as an additional information tool for the MOH to better guide PBF activities particularly in the context of expanding the initiative to four new regions.

#### **Box A2: Expanding Performance-Based Financing**

**General Considerations:** The PBF pilot project document had planned an impact evaluation, but due to start-up delays as a result of the withholding of health-related information and lack of resources, this evaluation was deferred. However, PNFBR requested the Component's support to conduct an evaluation of the process in order to draw lessons from the first two years of PBF implementation in the Kaffrine and Kolda regions. This will enable the MOH to build on the lessons, challenges and best practices of this pilot test and better design and implement PBF scaling up activities countrywide.

**Key results:** The preliminary evaluation report is currently being prepared and the team has shared initial findings with PNFBR and presented these at the 3<sup>rd</sup> Symposium on Health Systems Research in Cape Town in October 2014 (**See poster presentation in attachment 3**). At the quantitative level, analysis of 2012 and 2013 data collected by PNFBR has revealed that performances of signatory facilities have improved with a positive development of all PBF indicators. Quality scores have also improved for almost all elements on the quality checklist in first generation districts (Kolda and Kaffrine).

A semi-structured interview guide administered to beneficiaries and other stakeholders for the purposes of the qualitative survey revealed that beneficiaries are deploying efforts to enhance working and environmental conditions of health facilities. Initiatives were undertaken to address stock-outs of medicines and efforts made to improve strategic planning in the context of AWP development. Not only has communication between staff members improved, but there is a better distribution of roles and work as well as increased participation and enhanced capacities of community health workers.

More detailed and comprehensive results will be available in the PBF evaluation report being finalized.

**Lessons Learned:** PBF has contributed to increased accountability of service providers. They take more initiatives to enhance their performances and the quality of services (equipment, self-evaluation, improvement of the work environment). PBF implementation has also contributed to greater transparency in the management of health facilities: decisions regarding the management of PBF bonuses are taken in a consensual manner; activities are planned during meetings attended by all stakeholders. Lastly, the involvement of community-based stakeholders has greatly contributed to improving results.

**Outlook:** The MOH began preparing for PBF scaling up during the second implementation year. The Minister of Health instructed her collaborators to give higher priority to PBF implementation and established the PBF national program. Annual reviews and documentation reports reveal that satisfactory results have been obtained in terms of improving the quantity and quality of services delivered by health facilities concerned. The World Bank consequently included PBF extension as a major component in the formulation of its new project. All tools are now available, project personnel has been recruited and effective implementation of activities is scheduled in November 2014 with the enrolment of the Tambacounda, Sédhio, Ziguinchor and Kédougou regions.

**Synergy among interventions of TFPs: training on 5S in PBF districts in the Kaffrine region.** The Ministry of Health and Social Action (MOH) launched the 5S-KAISEN-TQM approach on enhancing the quality of services, in collaboration with JICA. In PBF, the quality score of services is a key indicator for measuring performance levels of health facilities. In order to promote synergy of interventions and hence

further enhance the quality of services delivered at health centers and posts, the National PBF Program (PNFBR), in collaboration with the National Quality Program (PNQ) and JICA, has commenced training of PBF beneficiaries on the 5S approach with the support of the HSS Component.

The 5S-KAISEN-TQM approach of improvement of the quality of services, supported by JICA, aims to improve the quality of health services through the improvement of the satisfaction of clients and the motivation of health personnel, and the reduction of errors and costs. It is based on the participation of personnel which takes responsibility and organizes its working environment through 5 principles represented by five (5) Japanese words starting with the letter “S” including: “Seiri” which means “Separate, suppress”; the second, “Seiton” ou “Locate, Systematize”; the third, “Seison” or “Shine, Cleanliness”; the fourth, “Seiketsu” or “Standardize, Set rules”; and the fifth, “Shitsuke” or “Respect the rules, be disciplined”.

The first training sessions organized with the support of the Component were conducted in the Kaffrine region at the Birkelane and Malem Hodar health centers. Prior to these sessions, training was conducted at the Koungeul health center with the support of the Belgian Technical Cooperation program. Training is attended by members of the district health team, all staff members of the health center, the health committee and the population including local government officials, youth and women’s associations. Staff of selected units, under the coordination of trainers, applied the 5S approach and prepared their 5S operational plan based on the findings of the evaluation. Twenty five percent of the Birkelane health center’s budget for PBF bonuses was earmarked for the operation of the facility and utilized in the context of the 5S approach for repairs on equipment and renovation of the premises of relevant units. At the end of six days of training and practical work on 5S, recommendations for health districts and the medical region were proposed and the next stages identified, in particular the establishment of a 5S committee in each health district.

**Development of a website.** Development of a website to facilitate the management, capture and transmission of PBF data was planned in the project document. The Component hence provided support this year for the presentation of the website and training of users. The presentation was made to the PBF National Program team familiarizing them with how to administer the website and manage information. Training sessions in Kolda and Kaffrine were attended by RHMT and DHMT members who were familiarized with how to access the PBF website, enter declared and verified data, monitor the completeness of data and print quarterly activity reports and PBF payment requests. The beta version of the PBF website has hence been operational since November 2013 and can be accessed via the address <http://www.fbr.sante.gouv.sn>. Performance data of beneficiaries are entered as soon as DHMTs received quarterly performance reports. However difficulties relating to the unavailability of the government IT developer and poor internet connection (website is hosted by ADIE) impedes proper functioning of the PBF website.

**Support for finalization of the World Bank health and nutrition project.** Within the framework of its support to extend PBF to other regions, the Component participated in various meetings to discuss and validate documents relating to the World Bank project. Four regions (Tambacounda, Sédhiou, Kédougou and Ziguinchor) will be enrolled with the support of the WB. During this year, meetings were held between WB experts, the MEF and the PBF/MOH team to (i) validate the scope of work of external audit organizations, (ii) discuss the PBF implementation manual, (iii) share the procurement plan, and (iv) recruit the organization in charge of conducting the impact evaluation. Beginning 2015, an independent audit agency will be in charge of verifying data in the six (06) PBF regions on a quarterly basis. Discussions on financial arrangements for implementation were held with the Department of Investments (DI) at the MEF. The latter proposed that a main account be opened and that it would act as authorizing officer. A sub-account will be opened at the DAGE/MOH for the transfer of funds to PBF beneficiary accounts to cover quarterly bonus payments. Other expenditures relating to PBF implementation and other project components will be submitted directly to the Department of Investments and DAGE/MOH for payment. The Health and Nutrition Financing project (PFSN) of the World Bank, based at the DGS, was signed and entered into effect in May 2014. The project team comprising the Coordinator, accountant and procurement specialist has been mobilized. The monitoring and evaluation specialist is being recruited.

### **3.1.2 Implementation analysis**

Considerable progress was made during Year 3 towards reaching milestones for the three activity areas under the sub-component “Management of the health system at the local level”. However, delays have been noted for certain milestones. In the area of health governance, preparation of job descriptions for members of regional and district health management teams has been delayed. Forums for consultation among actors in the healthcare sector were organized on a regular basis only in the Kaffrine and Kaolack regions. Effective progress has been made in strengthening capacities in planning, management and monitoring at the regional and health district levels. Of the ten intervention regions and three health districts, eight medical regions have received training on the ORCAP tool and integrated activities into AWP of responsibility centers, and the three districts of Bignona, Nioro and Thiès were the first to apply the tool at the operational level. Efforts to improve the administrative and financial management of medical regions and health districts were pursued through further training on stock accounting, computerization of the administrative and financial management system and production of annual financial reports in the Kaolack region (Thiès and Kolda are currently finalizing their reports).

Payment of milestones for 2013 has been effected and the six medical regions under direct financing for 2014 have signed their implementation letters. Milestones for the first quarter of 2014 in the six DF regions were paid as well as 2<sup>nd</sup> quarter milestones in the Kaolack, Thiès and Sédhiou regions.

The second PBF national review was organized and the second semi-annual documentation report prepared. The preliminary evaluation report of the PBF process is currently being finalized. 2014 performance contracts in the Kaffrine and Kolda regions were renewed and newly enrolled EPS’ and RHMTs in these two regions signed their first performance contract. Implementation of PBF activities in the Sédhiou, Ziguinchor, Kédougou and Tambacounda regions is yet to commence as a result of delays to launch the World Bank project on health and nutrition financing. Payment of PBF bonuses to beneficiaries in the Kaffrine and Kolda regions are still lagging behind due to delays in the submission of reports, and data verification and reconciliation. The PNFBR team and all beneficiaries in the seven districts have been briefed on USAID family planning policy requirements and training on the 5S approach is underway in the Kaffrine region.

### **3.1.3 Challenges, opportunities and perspectives**

Challenges under sub-component A relate to the stabilization of direct financing and performance-based financing pilot experiments. USAID’s decision to entrust direct financing implementation to the HSS Component from 2015 should facilitate validation of milestones and signing of implementation letters for Year 3 with the six medical regions before the end of December 2014. Establishment of the Steering committee, chaired by the SG/MOH, will strengthen the monitoring framework at the central level.

Challenges in the area of performance-based financing relate to delays in the transmission of quarterly performance reports and payment requests and in the convening of data reconciliation workshops by CRGs, which in turn result in significant delays in the payment of PBF bonuses. As part of efforts to clear this backlog, the Component met with the Secretary General of the MOH, chairperson of the Steering Committee, to discuss actions to be undertaken, including the recruitment of a regional adviser on PBF for each CRG who would be in charge of closely monitoring implementation of all PBF activities. The effective start of PBF implementation next quarter in the Sédhiou, Ziguinchor, Kédougou and Tambacounda regions is also a challenge to be met.

## **3.2 Achievements of sub-component B**

### **3.2.1 Key results**

**Incentivized support frameworks.**

In order to advance towards the “establishment of an incentivized framework to improve financial access to health care supported by risk-pooling mechanisms”, the Component continued to assist the MOH in the establishment of a UHC regulatory and institutional support framework and build capacities of key stakeholders.

**Assistance for the establishment of a UHC regulatory and institutional support framework.** The official launch, with the support of the Component, of the Universal Health Coverage Program by the Head of State on September 20, 2013 enabled Senegal to reach an important milestone translating the political commitment of the new authorities to extend healthcare coverage to the entire population, particularly those in the informal sector and rural areas. This national event was held following three interministerial council meetings on UHC during which the 2013-2017 action plan for implementation of basic UHC through MHOs was adopted. The action plan aims at extending health coverage to 75% of the workforce in the informal and rural sectors by 2017 in line with the target of the 2013-2017 national strategy for economic and social development. With the MOH’s decision to extend the DECAM demonstration phase to seven new departments on account of the interesting results obtained in the first three pilot departments of Kaolack, Kolda and Louga, the Component provided support for the organization of CRD meetings in the seven regions concerned to discuss the UHC strategic action plan and CDD meetings to launch the DECAM initiative in these seven new focus departments. Local stakeholders (locally-elected officials, administrative authorities, heads of decentralized services, representatives of community-based organizations) were able to fully understand their roles and responsibilities in implementing the UHC policy.

The Component also assisted the MOH in the organization of a study tour to Ghana from October 7 to 10, 2013 for a delegation led by the MOH Chief of Staff and comprising representatives of the MOH, MEF, National Assembly and locally-elected officials. The objectives were to: (i) learn about and understand the Ghanaian experience with regard to: (a) the context of universal health insurance; (b) financing systems; (c) organization of the system; (d) the National Health Insurance Authority (NHIA); (e) management mechanisms of the system and (ii) define an exchange and collaborative framework on UHC between Ghana and Senegal. Drawing from the lessons learned during this study tour, particularly at the legal and institutional levels, the Component is currently providing support to the MOH for adoption of a UHC law in Senegal. The draft, approved by a select committee, is currently being amended to take into account the MOH’s option of putting in place a stronger institutional framework to pilot UHC components for which it is directly responsible (development of MHOs and free healthcare initiatives).

As part of efforts to strengthen the institutional framework, the Component provided further support for the organization of the official launch of the national UHC interministerial steering committee. This event was chaired by the Minister of Health and Social Action and attended by representatives of locally-elected officials, technical ministries concerned, social security agencies, mutual insurance organizations, civil society, association of farmers’ organizations, decentralized administrative authorities (governors of regions) and technical and financial partners of the health sector. Effective establishment of this national platform and management frameworks at the local level will contribute to ensuring better coordination of interventions for implementation of UHC policies, in collaboration with technical and financial partners and decision-makers.

The Component also helped put in place financing mechanisms to channel subsidies for expansion of MHO benefits packages and to provide health coverage for the poor through MHOs. The government’s commitment to subsidize premium payments of all beneficiaries and fully pay premiums for poor and vulnerable persons materialized in the second quarter of 2014 with the effective mobilization of MHO subsidies, through a financing mechanism jointly managed by the MOH and MEF. This mechanism facilitated the gradual extension of subsidies to all functional MHOs in focus departments. To ensure a proper utilization of subsidies, the Component supported the signing of financing agreements between the MOH and regional MHO federations and between MHO federations and their member MHOs. The Component also provided technical and financial support to the CACMU to conduct MHO supervision missions in the pilot departments of Kolda and Louga. The absorption rate of initial subsidies was assessed during these missions and information on the number of beneficiaries that had paid their premiums in full gathered with a

view to mobilizing subsidies for financial year 2014 (see **Box B1** on the effective mobilization of subsidies through MHOs).

### **Box B1: Effective mobilization of subsidies through MHOs.**

The determination of Senegalese authorities to subsidize premium payments of all beneficiaries and fully pay premiums for poor and vulnerable persons through MHOs materialized during the official launch of the UHC program. The Head of State awarded each of the eleven chairpersons of MHO regional federations a symbolic check for 50 million CFA francs at this event. In light of delays in the establishment of planned financing frameworks (FNSS/CAPSU), the MOH proposed an alternative financing arrangement to the MEF consisting of opening a UHC account from which transfers will be made to beneficiary MHOs. The first disbursement was made in February 2014 in the amount of 173,880,000 CFA francs, representing 50% of annual contributions of 49,680 beneficiaries who were up-to-date with their payments as at October 20, 2013 in 64 MHOs. This first disbursement was made under the 2013 budget and only included general subsidies to extend benefits packages and enhance the quality of coverage for MHO beneficiaries. Other disbursements were made thereby progressively extending subsidies to all functional MHOs in the DECAM initiative's focus departments. A total of 77 MHOs established in twelve out of the fourteen DECAM initiative pilot departments received partial subsidies in the amount of 225,970,500 CFA francs for 56,260 beneficiaries who had paid their premiums in full.

5,956 poor and vulnerable persons in the Diourbel, Fatick, Kaffrine and Kaolack regions benefitted from targeted subsidies in the amount of 41,692,000 CFA francs. Targeted subsidies in these four regions respond to the need to pursue the actions of the equity fund established by PAMAS within the framework of the Belgian Technical Cooperation's support to the Government of Senegal. The MOH is increasing the number of poor people with healthcare coverage through MHOs with the enrolment of 48,000 recipients of family welfare grants. The process is being finalized with the support of the Component.

Mobilization of subsidies is an indication of the determination of political authorities to promote the development of MHOs in order to extend UHC to populations in the informal and rural sectors. This mechanism contributes to progressively replacing direct payments made by households at the moment of need, which constitute a major financial barrier to healthcare access and a primary factor of exclusion in the healthcare system. Subsidies will contribute to significantly increasing the number of members and beneficiaries in MHOs as benefits packages will be expanded and premium rates maintained at an affordable level for households. With stronger ties between UHC and social safety net programs, targeted subsidies will hence help improve healthcare coverage for poor and vulnerable persons.

**Strengthening of technical capacities of stakeholders.** The Component assisted the MOH in the development of three manuals contributing to the professional management of MHOs and thereby ensuring effective UHC implementation. The first manual on how to set up an MHO was utilized for the training of 130 regional trainers (10-16 trainers per region). Regional trainers will train members of MHO initiatives in all regions and help accelerate the setting up and expansion of MHOs throughout the country. In addition to the training manual on the characteristics and setting up of an MHO, a training manual on MHO administrative, accounting and financial management procedures was also developed with the support of the Component. This manual draws mainly on the streamlined version of the UEMOA chart of accounts for social insurance schemes. Training sessions on administrative and financial management organized in departments covered by the Component were attended by a total of 279 MHO administrators and oversight committee members (4-5 per MHO). The third manual, being finalized, centers on UHC management procedures in general with a special focus on the management of free healthcare initiatives. This manual will be a useful resource in efforts to streamline management of free healthcare initiatives so that they may contribute more effectively to the extension of healthcare coverage and access to quality healthcare services for target groups (pregnant women, children under 5 years, elderly persons). Training guides and management procedures manuals are vital tools for strengthening the technical capacities of stakeholders within the context of implementing the UHC policy in general and the DECAM initiative in particular.

#### **• EXTENSION OF HEALTH INSURANCE COVERAGE THROUGH MHO NETWORKS**

In order to advance towards the result: *“health insurance coverage is significantly increased through strengthened local networks and sustainable mutual health organizations”*, the Component, through the Kaolack, Kolda and

Thiès regional bureaus, provided support to consolidate implementation of the DECAM initiative in the first three pilot departments of Kaolack, Kolda and Louga, extend the initiative to the seven new focus departments, and continued its assistance to networks in its other intervention zones.

- **UHC extension in 10 demonstration departments.**

Continued support for implementation of the DECAM initiative in the first three pilot departments of Kaolack, Kolda and Louga resulted in a significant increase in the number of MHO members and beneficiaries with the establishment of 23 new MHOs and restructuring of 26 existing MHOs. It also supported, through regional bureaus, implementation of awareness-raising plans to extend the membership base and collect premium payments for all of these MHOs during the 2013-2014 financial year. Completion of the MHO setting up/restructuring process in these three departments led to the establishment of three departmental MHO federations to share large risks and ensure effective management of the complementary package at the departmental level through Government subsidies. Regional bureaus also helped CDS' organize quarterly meetings to assess UHC implementation within the department.

The Component supported the entire MHO setting up/restructuring process in all local government units within the seven new focus departments. Hence, 2,412 members of MHO initiatives were trained by the group of regional trainers in the departments of Rufisque, Mbacké, Mbour, Fatick, Kaffrine, Goudomp and Ziguinchor, 78 new MHOs established and 41 existing MHOs restructured. At the current stage of implementation of the DECAM initiative in these seven departments, 101 out of 119 MHOs have held their constitutive or restructuring general assembly meeting: 15 in Rufisque, 26 in Mbour, 29 in Mbacké, 12 in Goudomp, 4 in Ziguinchor, 5 in Kaffrine and 10 in Fatick.

#### **Box B2: Extending the DECAM initiative**

The Government of Senegal's decision to afford healthcare insurance to 75% of the population by 2017 requires sustained efforts for the development of local MHOs throughout the country in a timely manner and at reasonable costs. To contribute to achieving this objective, the HSS Component provides the MOH with support to implement a strategy for establishing MHOs within a perspective of developing a departmental network. The strategy consists of facilitating the simultaneous creation of MHOs in a given geographic area (a department, a health district). Key MHO parameters are harmonized within this geographic area, particularly the benefits package, user fees, premium rates and wait periods. Concurrent establishment of MHOs generates significant efficiency gains, with regard to time and resources, in the setting up process as MHO initiatives in the geographic area conduct joint activities (e.g. definition of parameters, draft statutes and internal regulations, joint training sessions, communication strategies, monitoring, etc.). Also, the purpose of creating a network is to widen the solidarity and risk-sharing base to include a higher number of members to cover large risks. In the case of Senegal, the geographic scope corresponds to that of a local government unit in accordance with the objective of "one local government unit, at least one MHO". This strategy was implemented in two phases: a demonstration phase in the departments of Kaolack, Kolda and Louga over the 2012-2013 period, and an extension phase in the seven new departments in 2013-2014.

At the operational level, the Component supported the establishment of a multisectoral monitoring framework at the departmental level (CDS) as well as the entire MHO setting up/restructuring process in all local government units within focus departments. These platforms helped mobilize leaders and stakeholders from different sectors to support and monitor implementation of health coverage in each department. Another major innovation is the training of a group of regional trainers who in turn conduct training sessions for members of MHO initiatives in each local government unit thereby contributing to speeding up the process in all focus departments. Implementation of this approach facilitated the setting-up/restructuring of 49 MHOs in all local government units in the departments of Kolda, Louga and Kaolack within a 6-8 month period. Building on lessons learned in the demonstration phase, 101 MHOs of the 119 initiatives supported in the seven new focus departments have already held their constitutive or restructuring general assembly meetings within a shorter time frame.

Also building on the lessons learned and experiences of the demonstration phase, the MOH is currently applying this strategy in other regions that are not covered by the HSS Component, with the support of partners such as the World Bank and Luxembourg's cooperation program. Adoption of this strategy by most partners supporting the UHC policy in Senegal contributes to improving efficiencies in policy implementation, strengthening synergies between interventions of partners, reducing fragmentation of initiatives and establishing a harmonized monitoring

Overall, community-based MHOs in the project area provided coverage to almost three hundred thousand (299,457) individuals by the end of September 2014 and half of these individuals had paid their premiums in full at the end of the fourth quarter. Forty percent of those up-to-date with their premium payments (56,260 people) benefitted from partial subsidies of the Government in the overall amount of 225,970,500 CFA francs. Seven thousand nine hundred and eight (7,908) poor and vulnerable persons also received coverage through MHOs and among these, 5,956 people received targeted subsidies from the equity fund in the total amount of 41,692,000 CFA francs. There is a total of 74,467 beneficiaries in the first three focus departments at the end of September, representing 25% of MHO members in the intervention zone. Twenty eight thousand nine hundred and seventy eight (28,978) of them had paid their contributions in full, representing 40% of this population and 21% of beneficiaries in the entire intervention zone.

**Support to other initiatives outside of demonstration departments.** During the third implementation year, the HSS Component continued its support to strengthen existing MHOs and MHO networks in its other intervention zones. Hence, all MHOs outside of the DECAM project zone, received direct support for the organization of their ordinary general assembly meetings, planning workshops and awareness-raising campaigns to expand their membership base. More specifically, the Thiès regional bureau assisted departmental MHO federations in the Dakar and Diourbel regions as well as district-level federations in the Thiès region to conduct quarterly monitoring of member MHOs and organize workshops to share data collected with regional stakeholders (medical region and regional federation of MHOs). The Kolda regional bureau assisted regional MHO federations in Sédhiou, Kolda and Ziguinchor to collect quarterly data from member MHOs in order to prepare requests for subsidies and the Kaolack regional bureau provided technical support to the medical region for the organization of a mission to supervise MHOs in the Kaolack region in the context of direct financing. The Kolda and Thiès regional bureaus also facilitated the organization of orientation workshops for healthcare providers in the Ziguinchor, Bignona, Goudomp, Khombole, Darou-Moukhty and Thiès health districts on the UHC policy in general and the DECAM strategy in particular.

Furthermore, all ten (10) regional federations in the project's intervention zone received support for the convening of statutory meetings and for activities to monitor, provide advisory-support and identify the needs of MHOs, particularly those that were facing difficulties. They were also involved in the development of procedures manuals and benefitted from close supervision for the utilization of government subsidies in compliance with the principles of sound management of public resources. The Component also provided technical and financial assistance for the establishment of a national federation of community-based MHOs that will serve as a support platform for dialogue and representation at the country level.

- **INCREASED ACCESS TO HEALTHCARE FOR VULNERABLE GROUPS**

**Continued support to the PLWHA project in the Kaolack region and effective extension to the Ziguinchor and Kolda regions.** The Component continued its support to reinforce the project on providing healthcare to PLWHA in Kaolack and its extension to the Ziguinchor and Kolda regions. Thus, at the country level, the working group comprising representatives of leading partners (DLSI, DAMS, CACMU, Abt and FHI) finalized the PLWHA project's operations manual. Other meetings of the select national committee discussed issues relating to the coordination, management and strategic monitoring mechanism. Furthermore, technical support and supervision of regional committees by the CNP continued to be provided at a distance or during field visits especially to new sites in the southern part of the country. At the operational level, the regional bureau of Kaolack took part in activities of the regional management committee in charge of implementing the project. It also provided institutional support to the project management unit in the form of office supplies and management tools. It supported the awareness-raising tour conducted by the regional federation of MHOs to public and private institutions (Salins and Chamber of Commerce) with the aim of diversifying FGS support partners. The Kolda regional bureau provided support

for the organization of CRD meetings to launch the project in Ziguinchor and Kolda. Subsequent to these meetings, initiative committees established at each new site held several information and awareness-raising activities aimed at other stakeholders (technical and financial partners, administrative and medical authorities...) for their involvement in providing healthcare to PLWHAs. The two regional bureaus participated in workshops to discuss the project's operations manual during which major barriers to its application, in light of the CMV+'s action plan, were identified and solutions proposed.

**Protection of other vulnerable groups.** The Component continued and strengthened its support to other initiatives for the protection of vulnerable groups. It continues to provide support for the coverage of children and poor people through the MHO for retired railway workers, widows and orphans, the MHO Yombal Fajju ak Wer, the MHO for Koranic school children in Thies, and the MHO Al Birou wa Takhwa of Guediawaye-Pikine in the Dakar region. It also supports the enrolment in MHOs of poor and vulnerable persons in the context of Government targeted subsidies, especially recipients of family welfare grants. A total of 5,644 benefitted from Government subsidies through MHOs.

### 3.2.2 Implementation analysis

Implementation of activities planned in the 2013-2014 action plan resulted in satisfactory progress towards reaching milestones set under the sub-component "Social Financing Mechanisms". The prospect of adopting a law on UHC and the official launch of the national UHC interministerial steering committee are significant steps towards establishing a regulatory and institutional support framework for social insurance schemes adapted to UEMOA regulations. Furthermore, the effective delivery of Government subsidies to MHOs from the second quarter and their extension to twelve of the fourteen pilot departments of the DECAM initiative, contribute to the introduction of new health financing mechanisms based on a combination of Government and household prepayment systems through MHOs, pending the establishment of CAPSU. This subsidy enabled MHOs to offer their members the entire benefits package planned under the DECAM initiative. In addition to the departments of Kaolack, Kolda, Louga and Rufisque, all other departments receiving Government subsidies developed a risk-pooling mechanism to share large risks. The mechanism is managed by the regional MHO federation pending the establishment of departmental federations, which is currently underway in zones covered by the Component.

With the completion of the MHO establishment/restructuring process in the departments of Rufisque, Goudomp and Ziguinchor, all local government units in these departments now have functional MHOs in addition to local government units in the departments of Kaolack, Kolda and Louga where the initiative was launched in 2013. In the departments of Mbour and Mbacké where the process is still on-going, 49 new MHOs have been set up of the 57 initiatives launched. Remaining initiatives in these two departments and on-going initiatives in the departments of Kaffrine and Fatick have scheduled their constitutive general assembly meetings in November 2014; in this way, the milestone "MHOs are functional in all local government units within the 10 focus departments" will be reached with a slight carry over to the fourth implementation year.

The PLWHA project has been effectively extended to the regions of Kolda and Ziguinchor and its implementation is continuing in the pilot region of Kaolack with the support of the Component. The procedures manual developed with the support of the Component to improve project management is currently being utilized. Other initiatives to provide healthcare coverage for vulnerable groups through MHOs are being conducted in some of the Component's intervention regions. In addition to the mobilization of targeted subsidies for the enrolment in 25 MHOs of **5,956** poor and vulnerable persons in the Diourbel, Fatick, Kaolack and Kaffrine regions, the Component is also providing the MOH (CACMU and DGAS) with support to enroll beneficiaries of family welfare grants in MHOs. This initiative targeting all functional MHOs countrywide will largely contribute to reaching the milestone "Health insurance coverage, through MHOs, is effectively provided to vulnerable groups in at least forty (40) MHOs".

### 3.2.3 Challenges, opportunities and perspectives

The lack of a suitable institutional framework and functional platforms for discussions and exchanges on UHC was identified as a major challenge in relation to the new context of advancing UHC, and Government and public stakeholders should play a prominent role in steering the process. The Government of Senegal's option to adopt a law on UHC and the establishment of a UHC inter-ministerial steering committee as well as regional and departmental committees to monitor UHC implementation may contribute to closing this gap.

With the Government's decision to speed up the extension phase so as to achieve a 75% rate of coverage by 2017 and interventions of new partners such as the WB, Luxembourg Cooperation Program and BTC, resource flow to UHC in general and MHOs in particular will become increasingly significant in the coming years. The magnitude of these resources raises the issue of absorption capacities of MHOs as well as transparency of financial transactions in compliance with procedures on the management of public funds. Development of a procedures manual with the support of the Component will contribute to strengthening the capacities of managers of the various UHC components. With regard specifically to MHOs, functional technical management units of departmental MHO federations could help strengthen the management capacities of MHO administrators.

Implementation of the various UHC components will probably result in a considerable increase in the use of healthcare services in a context where the lack of qualified human resources and equipment is manifest. The Government should therefore be encouraged to speed up implementation of programs aimed at strengthening healthcare delivery in terms of recruitment of qualified healthcare personnel and acquisition of adequate equipment for health facilities so as to anticipate on the demand for healthcare services as a result of UHC implementation. Likewise, finalization of the information system with the support of the World Bank and other partners could contribute to ensuring enhanced monitoring of UHC performance indicators.

## 3.3 Achievements of sub-component C

### 3.3.1 Key results

Policies, reforms and initiatives supported by the HSS Component in Year 3 contributed to reaching milestones set for the period relating to policies and reforms, and monitoring PNDS implementation. There were two key accomplishments in terms of developing strategic documents: the PNA's 2014-2018 strategic plan and the 2014-2018 community health strategic plan. Progress made towards achieving expected results by the end of financial year 2014 are analyzed below.

#### • POLICIES AND REFORMS

**Community health policy.** With the community health policy paper and strategic plan approved in 2014, the Department of Health now has all framework documents to improve the annual operational planning process of community health activities. The strategic plan effectively served as a reference document to develop the 2015 annual work plan (AWP) of the community health unit. The Component was closely involved in the entire process. HSS provided technical and financial support at all stages and intends to contribute to the financing of the 2015 AWP. The approach used to develop the strategic plan and the draft budget is summarized in the box below.

#### **Box C1: 2014-2018 community health strategic plan**

The 2014-2018 community health strategic plan was prepared with the joint support of HSS and PNSSC. This is the framework document for implementation of the community health policy designed in 2013 with the technical and financial support of the Component. It is worthwhile to recall that a working group (of which Abt-HSS was a member) in charge of developing Senegal's community health policy was established by circular nr. 441 MSHPP/DS/DSSP dated January 13, 2012. The MOH adopted a similar approach to develop the community health strategic plan with the

establishment of a steering committee and a drafting group. Abt-HSS was a member of both bodies. The process was inclusive and participatory. Decisions of the steering committee and drafting group were taken on the basis of consensus. The Minister of Health always had final approval authority. It shall be noted that the drafting group received assistance from the firm Mc Kinsey right through its work.

The drafting group, acting under the guidance of the MOH, constantly ensured consistency between the community health strategic plan and the policy paper with regard to the objectives, choice of priorities and policy options in light of the delicate issue of motivation of community health workers. The policy paper is structured around five strategic areas: (i) improving the geographical spread of community-based facilities; (ii) ensuring deeper integration of community health with the health system; (iii) improving the quality and broadening the healthcare service base at the community level; (iv) increasing the participation of communities and local government units in community health management; and (v) establishing a governance system and a general implementing strategy.

Priority projects were identified in the different areas and some are considered flagship projects such as the travelling midwives and utilization of ICTs in the community-based information system. The initial draft budget of the plan was estimated at 45.4 billion CFA francs, i.e. just over 9 billion CFA francs per year on average. This budget should however be revised since the travelling midwives project, which accounts for the bulk of spending, has been resized if the objective of recruiting 800 midwives is maintained.

**Drug policy and enhancement of the PNA's management system.** The 2014-2018 strategic plan of the PNA was presented during a national workshop held in Dakar on June 17, 2014. Organized by the PNA with the financial and technical support of HSS, this workshop was an opportunity for the MOH to discuss the document with over a hundred participants, all involved in the implementation of the drug policy. Key outcomes of this workshop are: (i) social partners strongly advocated with the Government to grant the PNA a status that is better suited to its activities; (ii) broad consensus was reached on the need to streamline procurement procedures for the acquisition of medicines; (iii) flagship projects were identified for the transfer of the main store and establishment of major regional centers to supply fixed and mobile PRAs; and (iv) TFPs renewed their commitment to contribute to the financing of the plan. PNA was requested to ensure follow-up of activities relating to the next stages identified, including finalization of the detailed budget and the narrative part of the document. These two activities were conducted with the support of Abt-HSS during the fourth quarter. The final document is expected to be submitted to the Minister of Health for approval and a roundtable meeting of TFPs is scheduled before December 2014. The box below provides an overview of guidelines, objectives and priority actions of the plan to be implemented through sixteen (16) well-identified projects.

#### **Box C2: 2014-2018 strategic plan of the PNA**

**Strategic guidelines.** On the basis of a thorough, participatory and inclusive situational analysis of the PNA conducted with the support of the firm Advise, five (5) strategic guidelines were identified to serve as a matrix for the PNA's 2014-2018 strategic plan: (i) increased service performance rate (increased availability and affordability), (ii) better control of forecasts, (iii) reinforced supply chain network; (iv) enhanced quality assurance system, and (v) increased communication.

**General objective.** The general objective is to ensure availability and affordability of drugs and essential products for populations. More specifically, this involves: (i) reducing processing time of procurement actions, (ii) improving the quantification of needs, (iii) reducing processing time of client orders, (iv) ensuring availability of a distribution chain at the peripheral level, (v) improving stock management, (vi) ensuring existence of a central purchasing body and PRAs that comply with storage and safety norms, (vii) optimizing resource management, and (viii) reinforcing the price equalization system by creating a balance between resources and expenditures.

**Priority actions.** The PNA must initiate the following priority actions in order to achieve the high ambitions set in the 2014-2018 strategic plan: (i) relocate the central store with the construction of a new and modern central purchasing

and storage facility, (ii) construct and renovate PRAs in compliance with best storage and distribution practices, (iii) improve the quality assurance system, and (iv) establish a new supply chain system.

Significant financial resources, estimated by the PNA at 15.5 billion CFA francs, are required for implementation of these priority actions. The Government and PNA will contribute slightly more than 5 billion and the remaining 10 billion is expected to be mobilized from TFPs. The Component is therefore assisting the PNA in the organization of a roundtable meeting of TFPs in early 2015 and to strengthen advocacy in the area of resource mobilization for funding of this plan.

The Component, through PATH, also continued to help reinforce the PNA's information and management system. Activities undertaken in this area during the period under review include the creation of a new inventory database and payroll system, programming of depreciation calculations based on the established structure, programming of links with accounting and/or business management units, backing-up of the database, verification of settings and modelling of the accounting system. Pharmacists and accountants attended a training session on the new software GESCOMP during the fourth quarter. Efforts deployed to strengthen the PNA's information system have begun to bear fruit: (i) the ability for the PNA to quantify drug needs at the country level has improved resulting in better monitoring of actual stock levels and needs of the eleven (11) PRAs, (ii) drug traceability has improved, (iii) delivery timeframes have been reduced, and (iv) the coding system of common reference frameworks and the security of commodities have been enhanced as batches and expiry dates are under control.

**Support to the MOH reorganization process.** Two key MOH actions in this area received support from the Component: reform of the health district and the PNLP organizational audit. The health district reform initiative is supported by the highest authorities of the MOH. The Component was, from the onset, involved in the work of the select committee established by the MOH to reflect on the content of this planned reform. Group ISSA was hence mobilized to help the committee conduct a situational analysis of health districts in Senegal and gather relevant information to draft the reform document. The last stage was the organization of a national workshop presenting the draft reform document. The major option adopted by the MOH in this regard is the creation of a health and social action service at the departmental level. This has already been integrated, in advance, in the latest version of the draft decree on reorganizing the MOH. Departmental services should therefore be operational as soon as the decree is signed. These services are planned to be the focal point for DHMTs in departments where the geographic scope of administrative units corresponds to that of the district. Discussions are still on-going on how to reorganize departments with at least two (2) health districts.

The consulting firm Advise, recruited by HSS, finalized the PNLP organizational audit exercise. As a first step, an assessment was performed through interviews and workshops organized by the consulting firm in June. The views of all stakeholders were gathered and findings of the report validated by the Steering Committee. The same participatory and inclusive approach was employed to propose solutions that were presented to the Steering Committee for approval prior to developing the corrective action plan including a draft organizational chart. The final audit report available since August 2014 will be widely disseminated during a national workshop to be attended by all stakeholders from central and regional levels.

**Repositioning family planning.** The Component, through Group ISSA, continues to provide the MOH with support to strengthen FP advocacy at the regional level. The strategy jointly adopted by the Component and DSRSE consists of harmonizing the formulation process of advocacy plans at the regional level based on a 3-stage participatory and inclusive approach: (i) organization of a technical meeting in preparation of a special CRD on FP with the objective of conducting a thorough assessment of the situation in the region with regard to FP and identifying barriers that could be lifted through advocacy, (ii) organization of a special CRD on FP chaired by the Governor of the region, and (iii) development of a regional advocacy plan based on the outcome of the special CRD. At the close of financial year 2014, the Component has organized technical meetings in preparation of special CRDs on FP advocacy in 9 out of 10 targeted regions

in its intervention zone. Dakar is the only region yet to organize this activity. Five (05) out ten (10) regions have organized their special CRDs on advocacy: Kaolack, Kaffrine, Sédhiou, Fatick and Ziguinchor. Draft FP advocacy plans are currently available in all of these regions except Kaolack. Abt renewed its financial commitment for implementation of these plans.

- **MONITORING OF PNDS**

**Multi-year Expenditure Programming Document.** The Component provided DPRS with support to prepare the health sector 2013 MTEF performance report and the 2014-2016 DPPD. The 2013 health sector MTEF performance report was presented at the JPR held in June 2014.

**Budget implementation reports.** The 2013 annual financial report of the DAGE and the financial implementation report for the first quarter of 2014 were prepared with the support of the Component and also presented at the JPR in June 2014. The Component continued its support to DAGE for the preparation of quarterly budget implementation reports on a regular basis. First, second and third quarter reports are available.

### **3.3.2 Implementation analysis**

Satisfactory results were obtained in the area of "policies and reforms" during the Program's third year. Support for the development of two policy papers or regulatory instruments on reforms was initially planned and in conclusion, the community health policy was supplemented by a five-year strategic plan and the PNA now has its strategic plan for 2014-2018.

In addition to these two strategic documents, the Component closely accompanied the process of drafting the health district reform document and provided assistance for the PNLP organizational audit. Actions undertaken to monitor PNDS are more systematic and relate to the DPPD process (annual revision and preparation of performance report). The Component provides continuous support greatly contributing to meeting deadlines for the production of the revised DPPD and related performance report in compliance with the Government schedule. Development of resource allocation criteria is yet to be done but the Component has increased its support to DAGE to ensure that annual financial statements and quarterly budget implementation reports are prepared systematically. All of these results contribute to the development of performance-based management.

### **3.3.3 Challenges, opportunities and perspectives**

There are three major challenges for FY 2015. The first is to launch the PNDS mid-term evaluation which will help identify bottlenecks and propose appropriate measures for enhancing performance of the health system. It shall be recalled that the 2009-2018 PNDS was developed prior to integrating social action services into the MOH and this could motivate revision of this plan particularly in light of changes brought about by the DPPD in a context of accelerating UHC implementation. The Component will assist the MOH in the PNDS evaluation process and specifically cover the fees of the consulting firm to be recruited to this effect. The second challenge is the reorganization of the Ministry with a special focus on reforming the health district to better take into account the realities of the 3<sup>rd</sup> phase of the decentralization process as well as decentralization efforts reflected in the upcoming establishment of regional departments of health. Mobilization of sufficient resources to finance the PNA remains the third challenge. The Component will provide special support for the organization of the donors' roundtable on financing the PNA's strategic plan. PNA intends to set up an organizing committee to prepare for this activity and has requested support from the HSS Component.

## **3.4 Achievements of sub-component D**

### 3.4.1 Key results

During Year 3, coordination and monitoring of the Health Program was enhanced through organization of inter-agency meetings on DF monitoring and implementation, finalization of the 2014 integrated action plan and preparation of the 2015 plan. The 2011-2016 Health Program's Steering Committee also met and regional bureaus played their coordination and monitoring role throughout the year. The Component also organized coordination meetings this year and held a retreat to discuss pilot experiments, monitor implementation of the 2014 AAP and develop the 2015 AAP. The Component's database continued to be updated and an audit performed on the quality of MHO data. The Component prepared and submitted its activity reports to USAID on a regular basis.

- **COORDINATION**

**Monitoring DF implementation.** Components met on several occasions during this year to monitor DF implementation. Inter-agency coordination met on December 6, 2013 in the conference room at the Abt offices to discuss funding allocation between the six (6) regions selected for 2014, assess implementation of 2013 direct financing activities and set up a monitoring committee. Following this meeting, the USAID Health team met with CAs of the Health Program in Thiès to assess progress in direct financing implementation. COPs then met on January 17, 2014 to agree on funding allocations for the six (6) regions and prepare for the first direct financing review workshop held from January 21 to 23, 2014.

Implementing agencies also met on Friday, April 25, 2014 at the Component's offices to discuss closing out implementation letters for the Kaolack, Kolda and Thiès regions, preparation of direct financing implementation letters for the Diourbel, Kaolack, Kolda Sédhiou, Thiès and Ziguinchor regions and review progress in the production of the summary report on the rapid review of direct financing activities. A meeting with USAID to discuss direct financing was scheduled on April 30, 2014 as well as a meeting between the committee in charge of monitoring direct financing and coordinators of regional bureaus. The guidance note on planning was updated.

A meeting of COPs was held on Tuesday July 8, 2014 to discuss payment requests for the first 2014 DF milestone, organization of the workshop to revise DF deliverables, and preparation of the 2015 integrated action plan. Agencies then participated in the national workshop on the revision of direct financing deliverables effectively held in Mbour from July 14 to 16, 2014 and then met to prepare for the meeting of the direct financing steering committee held on October 21 as well as the workshop on the determination of 2015 DF milestones and deliverables planned in November 2014.

**Integrated action plan of the Health Program.** The guidance note on the integrated action plan prepared in Year 1 provides for the development of a preliminary integrated action plan in October to enable regional bureaus to provide effective support for the development of AWP of medical regions and health districts. A consultant was recruited in October 2013 to facilitate production of the 2014 preliminary integrated action plan within the required timeframe. The consultant collated the core elements of action plans of the various components and a two-day workshop attended by all components was held on October 23 and 24 in Mbour to discuss the first draft proposed by the consultant. An inter-agency meeting was organized on November 13, 2013 to discuss the second draft of the 2014 preliminary plan submitted on November 11 by the consultant. It was decided to hold a meeting between coordinators of regional bureaus and action plan focal points from the different components on November 18, 2013 at the offices of Abt to fill in information gaps, make corrections and provide clarifications requested by coordinators of regional bureaus. The meeting was finally held over a four-day period given the numerous corrections that had to be made to this version of the 2014 integrated action plan. The final version was available on December 12 and utilized by regional bureaus of the Health Program during the preparation of 2014 AWP of regions and health districts.

The meeting of COPs on July 8, 2014 excluded recruitment of a consultant to develop the 2015 integrated action plan and proposed that staff of the various components in charge of monitoring and evaluation take on this task. The latter thus met in August and prepared a draft work plan for developing the integrated action plan and proposed terms of reference and a program for the workshop to develop and validate the 2015 integrated action plan. COPs met on Tuesday September 16, 2014 at the Abt offices to amend the annotated work plan and agreed on a format as well as dates for convening the 2015 integrated action plan development workshop. Scheduled in October 2014 at Somone, the workshop will only be attended by members of the select committee, whereas COPs will meet at the Abt offices to validate the document.

**Meeting of the Health Program's Steering Committee.** The Health Program's Steering Committee is to meet twice a year. The first meeting of USAID/Senegal Health Program's Steering Committee was held on February 6, 2014 at King Fahd Palace. Staff of the Component and of other components took part in this meeting as well as regional bureau coordinators and chief regional medical officers or their representatives, sponsored by the Component. Presentations made by a USAID team focused on the innovative financing initiatives (PBF and DF), accomplishments in 2013 with an execution rate of 85% for the integrated action plan, and perspectives for 2014. Ownership of the process by USAID was noted as well as the satisfaction of the newly appointed Director. The MOH expressed gratitude particularly for USAID's alignment to national procedures, strengthening of national capacities and support in terms of human resources. The second meeting is scheduled on October 30, 2014 at King Fahd Palace.

**Regional bureaus of the Health Program.** Health Program regional bureaus continue to play a significant role in Program coordination. Regional bureaus provided support for the development of 2014 and 2015 AWP in the Component's 10 focus regions. The integrated action plan, shared beforehand with regional bureaus, served as a key tool for this support. Quarterly coordination meetings of regional bureaus were an opportunity to share the 2014 preliminary integrated action plan, determine how they will support AWP development workshops of health districts and consolidation workshops of medical regions for 2014, monitor activity implementation, and finalize their activity reports. Regional bureaus also participated this year in quarterly coordination meetings of medical regions and health districts providing both technical and financial support. These meetings are opportunities to share and discuss information and ensure effective implementation of activities.

Regional bureaus play a key role in implementation of the direct financing mechanism at the regional level. They helped prepare direct financing documents, finalize the procedures manual and implement direct financing activities. They played an important role in the identification of milestones and related indicators, which are the basis of direct financing contracting arrangements. They supported the introduction of direct financing in each of the pilot regions of Kaolack, Kolda and Thiès. Regional bureaus represent the Health Program and all implementing agencies at regional verification committees and monitor implementation of direct financing activities at the regional level.

Furthermore, Administrative and Finance officers of the five components and regional bureau coordinators met in Dakar to prepare a draft procedures manual for the Health Program's Regional Bureaus submitted to COPs for approval. Also, Administrative and Finance Officers of regional bureaus were trained on the "ISMS" tool, which aims to simplify accounting and financial monitoring through the electronic filing of supporting documents via the internet. This training program promotes effective collaboration by allowing the head office as well as the other bureaus of the HSS Component to have access to real-time financial information through the internet.

## • MONITORING/EVALUATION

**Coordination meetings of the Component.** The Component organized its coordination meetings this year on a regular basis. These meetings discussed activities implemented or monitored by national advisers and sub-contractors. Issues discussed at this meeting include preparation of the fourth quarterly and annual

reports for Year 2, the 2014 preliminary integrated action plan, the report on the UHC study tour in Ghana, the UHC interministerial council, extension of the DECAM initiative, MHO subsidies granted by the Government, MHO training sessions, development of the procedures manual on management of free healthcare initiatives, USAID feedback on annual and quarterly reports of components, reactivation of the direct financing monitoring committee, the PNLP audit, reorganization of the MOH (PNLP, DGS), support to PNA, the 2015 preliminary integrated action plan, indicators, archiving of project documents, PBF and DF reviews, development of the community health strategic plan and that of the PNA, evaluation of the PBF process and FP support.

**Annual retreat of the Component.** The Component organized its annual retreat from March 26 to 28, 2014 in Somone. Discussions centered on monitoring implementation of DECAM, PBF and DF pilot projects, the mechanism for sharing experiences and results, and linkages between health governance and financing initiatives. The gender sensitive approach, monitoring and evaluation of the Component, archiving, utilization of the SharePoint application and communication were among other issues discussed during this retreat. About thirty people including the COP of HSS, 5 national advisers, 3 regional bureau coordinators, 9 regional advisers, 4 administrative and finance officers (1 from the national level and 3 from regional levels) and representatives of sub-contractors (1 from PATH, 2 from FHI360, 1 from ACA and 2 from CRDH) participated in this highly appreciated activity, particularly the venue and methodology.

**Activity reports of the Component submitted to USAID.** Quarterly reports and the annual report for Year 2 were prepared with contributions from regional bureaus, advisers and the administrative and finance officer and submitted to USAID. Progress made towards reaching milestones was hence measured through the four sub-components on a regular basis. Difficulties faced during implementation of activities were also identified in each report and the financial situation of the Component presented. The annual report also includes the table of indicators submitted previously to USAID. PBF indicators were modified and 2013 results updated. USAID feedback on the Component's annual reports were received and analyzed. The annual report template was revised to better highlight progress made towards enhancing performance of the health system and orientations for Year 3. The template for quarterly reports was also modified as of the second quarter to align with the USAID proposed model.

Nine bi-weekly updates were prepared and submitted to USAID and focused on CDD meetings organized on UHC, preparations for the second national review of the PBF project, implementation of the PBF Senegal application, training of trainers' workshop on UHC for MHOs, development of the procedures manual on the management of free healthcare initiatives, the national review of the PBF project and the DF project, workshops on PBF data reconciliation, supervision of PBF beneficiaries, signing of financing agreements between the Minister of Health and Social Action and regional MHO federations in the eleven regions, validation of PNA's 2014-2018 strategic plan, signing of PBF contracts for 2014 and training of PBF beneficiaries on the 5S approach organized by the national PBF program (PNFBR) with the support of the Component and in collaboration with the national program on quality (PNQ) and the JICA team.

**Data quality audit.** In order to meet data quality requirements, auditing the quality of the Component's data was planned in the 2014 action plan. In November 2013, a USAID team conducted a similar exercise at the national office and recommended an assessment of basic data quality, particularly those relating to MHOs (see memo of audit team dated February 4). A mission was hence conducted in the ten focus regions of the Component from late May throughout the month of June to assess the quality of data produced by MHOs. During this mission, working sessions were held with regional MHO federations and MHOs visited. Discussions with representatives of 10 regional federations and 24 MHOs as well as consultation of registers and verification of data collection and monitoring tools helped to gain insight into the functioning of MHO federations. Changes that occurred in 2014 relative to MHOs and that have an impact on data were noted. Output quality was assessed, certain information completed, corrected or validated, the monitoring form shared and recommendations made to enhance data collection and monitoring.

**Action plan prepared and submitted to USAID.** Annual action plans of the Component were prepared and submitted to USAID on time. The action plan for Year 3 was finalized after integrating observations made by USAID and amendments made during the development of AWP of districts and medical regions. It was sent to USAID in January 2014. Regarding the action plan for Year 4, a workshop was organized from August 04 to 06, 2014 to identify, budget and select priority activities to be implemented in collaboration with partners at the Ministry of Health and Social Action. This workshop was attended by staff from the national office, regional bureau coordinators, HSS and HF advisers as well as the Component's portfolio manager. During this workshop, implementation of activities contained in the 2014 action plan and difficulties encountered were reviewed as well implementation of the 2014 budget. Priority activities of the fourth quarter of 2014 plan were identified, budgeted and rescheduled. Following this workshop, regional bureaus met with medical regions to identify DF activities and provide the Component with the necessary information to prepare DF budget forecasts per region. This information was attached to the 2015 action plan submitted on September 1 to USAID.

**Database and archiving of Component documents.** Second year data was entered and corrections made. For Year 3, information covering the period from October 2013 to August 2014 was entered and verified before the end of September 2014. The number of participants in training sessions supported by the Component could hence be documented. The database also provides information on the extent to which planned activities have been implemented. The directory 'HSS drive' on the server is updated on a regular basis for archiving purposes. Most of the Component's documents can be found in this directory.

### 3.4.2 Implementation analysis

Five coordination-related activities were planned in the Component's action plan as well as ten planning activities, six monitoring activities and the production of success stories. At the end of the fourth quarter, establishment of a record keeping system at regional bureaus, orientation sessions on success stories for staff of the Component, drafting and dissemination of success stories and joint semi-annual supervision of regional bureaus were not conducted. Also, inter-agency working groups were not functional and related activities were therefore not carried out. A total of 15 out of 25 activities were implemented, representing an implementation rate of 60%. However, training on how to write success stories no longer appears to serve a purpose as documentation in this regard was shared by head office and success stories will be prepared during the first quarter of 2015 along with the annual report. Establishment of a record keeping system at regional bureaus was rescheduled to Year 4.

### 3.4.3 Challenges, opportunities and perspectives

The main constraint is the concomitant preparation of the integrated action plan and fourth quarter and annual reports. A consultant was recruited to develop the 2014 integrated action plan but this did not prevent the mobilization of resources persons from components and coordinators of regional bureaus to ensure the timely delivery of a quality document. For the 2015 integrated action plan, the option was to put in place a select committee composed of M&E Officers, other staff members of components and regional bureau coordinators. It proved difficult to bring these resource persons together in August and September and the workshop was hence rescheduled to October. With changes in the MOH planning cycle, which now commences in May, the integrated action plan can no longer be used as a reference document for formulating AWP but rather as a means of communicating with the MOH on achievements of the previous year and prospects for the coming year. It will also serve as a reference document for the Health Program's Steering Committee meetings. Consequently, though the integrated action plan is relevant, its preparation would be preferable after submission of annual activity reports.

The absence of regular and timely reports or activity updates for the preparation of bi-weekly updates (two per month) and updating of the database was also a constraint. Despite the Administrative and Finance

Officer's request to attach reports or activity updates to supporting documents, the problem persists as a result of the succession of activities. Only nine bi-weekly updates were therefore produced this year.

Two other challenges in program coordination are the frequency of inter-agency meetings and participation of regional bureaus in coordination meetings of medical regions and health districts. Monitoring of direct financing was an excellent opportunity to facilitate exchanges between components and medical regions. During Year 4, efforts should be made to ensure effective organization of inter-agency meetings attended by all components. Regional bureaus should also ensure better communication with medical regions to increase their participation in coordination meetings of medical regions and health districts.

## 4 CROSS-CUTTING ISSUES

---

### 4.1 GENDER MAINSTREAMING

Gender mainstreaming is addressed in the Component's interventions from two angles: taking full account of the specific needs of women or men when determining benefits packages of financing mechanisms supported by the Component, and empowering women and men in the health sector through their participation in the implementation of interventions supported by the Component and their representation in decision-making bodies of new organizations established with the support of the Component.

The PBF project was designed to address issues relating to coverage and quality of healthcare services for mothers, newborns and children as well as disease control, thus health problems specific to women are a priority in the PBF benefits package. Six (6) specific indicators focus on increased coverage and enhanced quality of healthcare services for women.

Furthermore, as in the second year of implementation, men and women are well-represented as beneficiaries of the PBF project.

Granting of partial and targeted subsidies and their progressive extension enabled MHOs established in the focus departments to enhance their benefits packages. Benefits packages include services that take into account the healthcare needs of men and women: reproductive health, family planning, diagnostic tests, generics and brand name drugs. Moreover, commencement of targeted subsidizing and enrolment of family welfare grant recipients will facilitate financial access to healthcare for vulnerable groups. The significant level of participation of women in the various implementation phases of the DECAM initiative was enhanced. Women are increasingly represented in decision-making positions in newly established MHOs (chair, treasurer, secretary general, oversight committee).

A draft of the HSS Component's "gender" strategy is available and will be submitted to USAID as soon as it is finalized.

### 4.2 COMPLIANCE WITH ENVIRONMENTAL REGULATIONS

Prior to the approval of our contract, the initial environmental evaluation of USAID/Senegal's Health Program was approved by Bureau Environmental Officers in Washington D.C. It was determined that all intermediate results of the Program qualified for categorical exclusion with the exception of those concerning the supply of nets and residual spraying – which do not involve the Component. The HSS Component is drafting an environmental compliance strategy to be submitted to USAID upon finalization.

### 4.3 COMPLIANCE WITH FAMILY PLANNING LEGISLATION AND POLICY REQUIREMENTS

During Year 3, the HSS Component initiated actions to ensure compliance with FP policy requirements. With the support of the USAID Health Office, the Component organized training sessions for staff of the PBF national program and PBF beneficiaries in the seven districts of Kolda and Kaffrine. Subsequent to the training session on US Government family planning legislation and policy requirements attended by the PBF adviser and in view of the fact that FP recruitment rate is a PBF indicator, the Component organized an orientation session for staff of the PBF national program. In addition to USAID guiding principles and areas covered by the Thiart amendment, discussions also focused on communication and actions to be undertaken in the case of vulnerabilities or violations. An action plan is also to be prepared for supervision and monitoring purposes.

Workshops held in health districts to sign 2014 performance contracts were an opportunity for the PBF national program to present USAID family planning requirements to each district. Emphasis was placed on areas relating to the payment of bonuses/financial awards to staff for meeting numerical targets in order to provide a clear explanation on reasons why PBF complies with these requirements. The PBF national program has committed to provide health districts with support to monitor FP compliance. DHMTs were requested to inform the PBF national program of cases of vulnerability for corrective measures to be jointly taken with the support of the HSS Component. Wall posters on contraceptive methods were distributed. Staff of 116 SDPs (health posts and centers) and 7 DHMTs in the Kolda and Kaffrine regions were trained.

The HSS Component is drafting a strategy for compliance with family planning policy requirements to be submitted to USAID upon finalization.

## 5 LESSONS LEARNED

---

**Strengthening the capacities of medical regions and health districts in planning, management and monitoring.** A computerized management system of health centers and medical regions contributes to enhancing health governance through transparency in the management of revenue generated from the sale of tickets and medicines, and improve the information system.

**Direct financing.** DF is an opportunity for regions to finance priority activities that were previously not funded. Its implementation further empowers chief regional and district medical officers in the resolution of healthcare issues and enhances their commitment to implement AWP. DF provides an opportunity to introduce technological innovations in the health system. The framework for activity planning, monitoring and coordination of health districts and the medical region is currently being reinforced in pilot regions. Regional validation committees, multi-disciplinary in nature and chaired by the governor of the region, met regularly to review deliverables before submission of payment requests.

**Performance-based financing.** PBF contributes to increased accountability of service providers. They take more initiatives to enhance their performances and the quality of services (equipment, self-evaluation, improvement of the work environment). Collaboration among the various stakeholders (local government units, TFPs, health committees) has also strengthened as they meet within CRGs to jointly validate data produced by beneficiary facilities. PBF implementation also contributes to greater transparency in the management of health facilities: decisions regarding the management of PBF bonuses are taken in a consensual manner; activities are planned during meetings attended by all stakeholders. The PBF project is well received by service providers. Lastly, the involvement of community-based actors (health huts, relay workers) greatly contributed to improving results. Availability and analysis of performance data helps strengthen the capacities of providers in focusing efforts of local stakeholders on objectives to enhance delivery and quality of priority services. However, inadequacies in the accountability of CRGs with regard to decision-making and activity implementation at the local level prolong time limits set for the various stages of the PBF cycle.

**Social financing mechanisms.** The Government of Senegal's decision to adopt a law on UHC and the effective establishment of UHC monitoring bodies are significant steps towards creating a favorable legal and institutional environment for UHC. The satisfactory level of progress in the implementation of the UHC policy in general and the DECAM initiative in particular is attributable to the commitment of administrative authorities (governors, préfets, sous-préfets) and the mobilization of key community-based stakeholders. The Government's effective contribution in the financing of MHO premium payments has provided MHOs with greater credibility and could be an incentive for populations to enroll in MHOs. Development of local leadership through training by the pool of trainers has increased the confidence of populations and prompted their participation in the DECAM initiative. Finally, enrolment of family welfare grant recipients in MHOs will strengthen relations between the UHC and other social safety net programs.

**Policies and reforms.** Ownership of health policies by healthcare workers will certainly depend on the expected impact policies will have on system performance as well as material benefits that workers expect to derive from these. The outcome of the process could be delayed if there is the slightest risk that part of the personnel will lose its benefits. The reform of the health district is a perfect illustration.

## 6 GUIDELINES AND PRIORITIES FOR YEAR 4

---

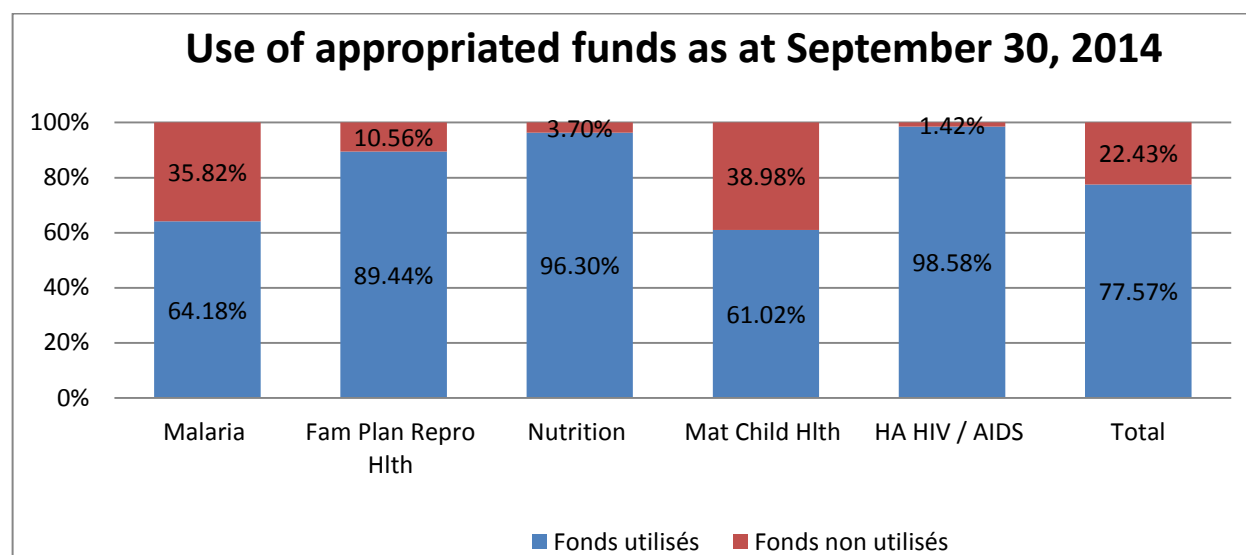
The annual action plan for Year 4 of the HSS Component was prepared taking into account changes in the sector and progress made during first two years of the Component. Enhanced decentralization, reform of public financial management, enhanced governance and universal health coverage have been identified by the new political authorities among priority issues on their agenda. Furthermore, central and regional services of the MOH are currently being reorganized. A UHC strategic plan was developed and resources earmarked to support its implementation. The PBF initiative was extended to seven health districts in two regions and a World Bank project on Health and Nutrition Financing is being developed which will extend PBF to four other regions. Finally, USAID/Senegal is committed to implementing a package of reforms relating to the way it does business, including the Implementation and Procurement Reform (IPR) which introduces direct financing mechanisms at the central and regional levels with the support of the Health Program's implementing agencies.

The annual action plan for Year 4 will continue to set the stage for the HSS Component to seize opportunities offered in order to improve health system performance. The Component will focus on extending high impact interventions in the areas of family planning, maternal health and child health through consolidation of mechanisms for planning, implementation, management and financing developed during the first three years. Based on these general guidelines, the following priorities, defined by the USAID Health Team, will steer development of the 2014-2015 action plan:

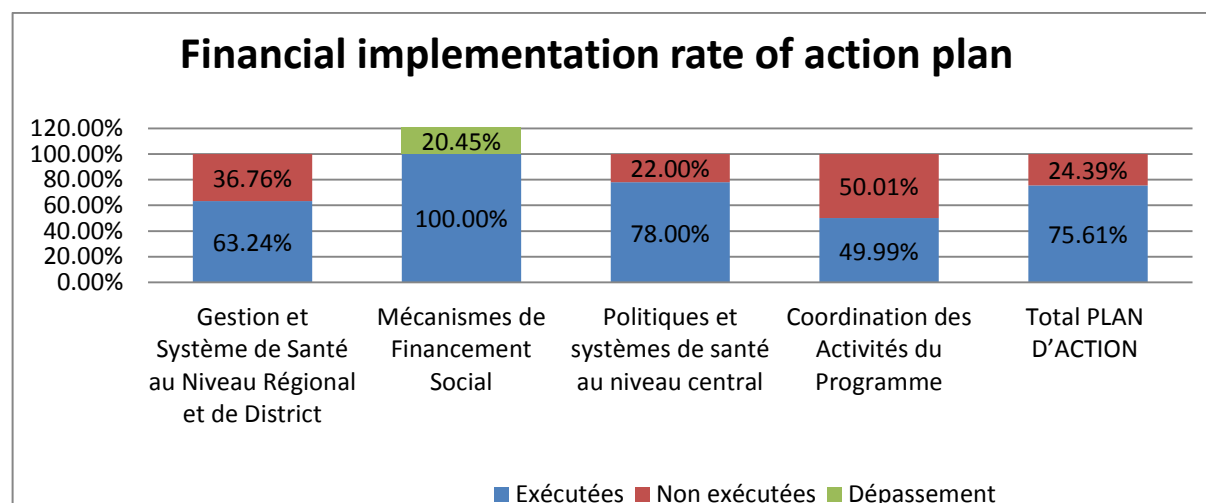
- Support for implementation of universal health coverage in general, and coordination and implementation in particular;
- Implementation of Performance-Based Financing (PBF) activities and coordination with the World Bank program;
- Supply chain management assistance (and MOU DSRSE/PNA);
- Family planning, maternal health and child health interventions (advocacy) with proven results/impact;
- Implementation of direct financing activities;
- Coordination of activities of regional bureaus and integrated work plans;
- Support to reforms at the central level (legal framework and reorganization of the MOH);
- Increased commitment to UHC (federations, steering committee).

## 7 MANAGEMENT AND ADMINISTRATIVE ISSUES

Total expenditures of the HSS Component at the end of September 2014 was US\$ 14,061,133.22 out of a total budget of US\$ 18,127,514.33 i.e. an overall execution rate of 77.57%. This is reflected across all financing sources, also rated at almost 80% in terms of spending.



The financial execution rate of the Health System Strengthening Component's action plan for Year 3 is 75.61%. This rate has increased by 22.55 points compared to the previous year and the increase is echoed in all activity areas, particularly the social financing mechanisms sub-component, which reached a financial execution rate of 120.45%. Financial execution rates of sub-components relating to management and health system and health policies and reform also increased significantly. However, execution rates of these two sub-components are still contained by (i) delays in the payment of bonuses, (ii) failure to implement health sector MTEFs at the regional level, and (iii) low level of implementation of activities in support of the FP action plan.



A contract modification to increase the HSS Component's budget ceiling has been initiated. This increase shall amount to a total of US\$ 4.7 million. The HSS Component's budget ceiling therefore increases from US\$ 22 million to US\$ 26.7 million. This will allow the HSS Component to take full charge of DF management in the 6 beneficiary regions for the remaining two years of the Health Program and also pay PBF bonuses for the July-December 2014 period.

The Component amended the contract with PATH enabling this sub-contractor to provide support to initiatives of the PNA during Year 4 of the project. A package of additional activities relating to the establishment of mobile PRAs, dissemination of the strategic plan, management of free drugs in the 10 regions, the annual field monitoring and inspection mission, support to DPM for training and orientation of 04 new pharmacists-inspectors will be implemented by PATH. These activities require additional effort and financial resources and hence a budget increase amounting to US\$ 56,861 as well as the acquisition and equipping of a truck for transporting medicines to the southern part of the country. A budget reallocation was submitted and approved by USAID.



## ATTACHMENT I: PROGRESS ON THE ACTION PLAN/INDICATORS

TABLE 2: INDICATOR TABLE

#	Indicator	Disaggregated by	FY13	FY14					Performance FY14	Observations
				FY14 Target	Status Q1	Status Q2	Status Q3	Status Year3		
1	Proportion of health districts where the functions of DMO and those of the chief medical officer at the health center are separated	Region	31%	100%	NA	NA	NA	ND		Data was collected during this quarter and will be presented next quarter.
2	Proportion of Service Delivery Points (SDP) that have displayed the cost of medicines and services	District	63%	95%	NA	NA	NA	ND		
3	Proportion of health districts with a technical execution rate of AWP <sub>s</sub> ≥ 80% <sup>1</sup>	Region	22,9	100%	NA	NA	NA	35,9%	56,7%	Thirty nine health districts provided data for the two years. 14 health districts had rates higher than or equal to 80% in 2013 compared to 8 in 2012. Among health districts that reached an 80% rate,

<sup>1</sup> Les taux d'exécution calculé au cours d'une année concernent l'année précédente mais les taux de 2012 ont été pour la plupart fournis au cours de l'année 2014. La moyenne contenue dans le tableau concerne les 35 DS pour lesquelles l'information est disponible pour 2012 et 2013

										the best performances were recorded in Médina Yoro Foulah, Tiadiaye, Goudomp, Ziguinchor and Joal. They progressed between 106 and 60%. The highest rates were recorded in Guinguiné (100%), MYF (95%), Goudomp (85%), Tivaoune (84%) and Ziguinchor (84%).
4	Number of medical regions that have organized a high quality JPR	-	100%	100%	NA	NA	100%	100%	-	All regions organized their JPRs prior to the national JPR with the support of the Component or other partners. The situation is 100% satisfactory.
5	Proportion of verification reports received by CRGs	-	100%	100%	100%	0%	100%	100%	-	Reports were prepared after each verification mission. The situation is 100% satisfactory.
6A	Number of reimbursement requests received by the national PBF program (BAP)	-	100%	100%	24.8% (76/306)	24.8%	62.4% (191/306)	100% (306/306)	-	During the first two quarters, only 38 beneficiaries had signed their contracts. The 77 other beneficiaries signed their contracts in July 2014 bringing the total number of beneficiaries to 115.
6B	Proportion of payment requests submitted to the Component	-	100%	100%	0%	24,8%	62,4%	100%	-	

6C	Number of payments received by beneficiaries that have signed PBF contracts	-	45	306	0	76	191	306	-	
7	Number of health districts involved in performance-based financing	-	7	16	7	7	7	7	43,8%	The Component is to accompany the World Bank for extension to other districts but the WB project is yet to commence.
8	Number of MHOs that received public subsidies following the establishment of mechanisms by the government	Region	-	50	0	64	75	77		Subsidies (partial and targeted) became effective in 2014 and are available for all functional MHOs. The 64 MHOs in the first 3 focus departments were the first to receive subsidies. Subsidies were extended to other focus departments as and when the required documents were submitted. Of the 77 recipient MHOs at the end of the year, 25 also received targeted subsidies for poor and vulnerable groups.

9	Number of beneficiaries covered by community-based MHOs	Region	336739	660000	295884	281224	273108	299457	-	<p>The slight decrease in comparison to Year 2 is a result of clean-up operations conducted by some MHOs in connection with the preparation of subsidy requests. Nonetheless, new MHOs established with the support of the Component have commenced their membership recruitment campaigns and the number of beneficiaries should considerably increase especially in light of subsidies.</p>
10	Number of vulnerable persons covered through MHOs with the support of a third-party payer	Region	55204	66000	10650	6361	3235	7908		<p>These figures have dropped considerably because NGOs such as World Vision have stopped subsidizing school children and other vulnerable persons. 5,644 of these vulnerable persons benefitted from government subsidies. A sharp increase is expected in the coming months with the enrolment in MHOs of households receiving family welfare grants.</p>

11	Number of policy papers approved and regulatory acts adopted for implementation of policy initiatives developed by the EIPS	-	2	≥ 1	0	1	1	2	-	Validation of the PNA's strategic plan and the community health policy paper (health district reform document is available but is yet to be validated).
12	Health sector budget as a percentage of the national budget	-	10,7%	15,0%	-	-	-	ND	1,3%	Data will be available from March 2015.
13	Deadline for production of the performance report of the health sector MTEF for year n-1 is met (May)		Yes	Yes	-	-	Yes	Yes		The report was produced in May as scheduled.
14	Amount allocated (in CFA francs) to districts and medical regions by Program components through the direct financing mechanism		496950592 FCFA	1000000000 FCFA	-	0	999990715		-	2014 implementation letters were signed in June for six regions. During the fourth quarter, the six regions reached the first milestone and Thiès, Sédhiou and Kaolack reached the second.

15	Amount allocated (in CFA francs) to districts, medical regions and EPS' by Program components through the PBF mechanism for the payment of bonuses		23564521 FCFA	320000000 FCFA	0	12236409 FCFA	22540177 FCFA	97034051 FCFA	30,3%	During the first two quarters, only 38 beneficiaries had signed their contracts and received bonus payments. The 77 other beneficiaries signed their contracts in July 2014. Total bonus payments in the fourth quarter amounted to 62,257,465 CFA francs.
16	Proportion of progress reports of the Component prepared within the required time-limit	-	100%	100%	100%	100%	100%	100%		All reports were submitted on time but only nine (9) bi-weekly updates were produced.

## ATTACHMENT 2: FINANCIAL REPORT OF THE ACTION PLAN OF THE COMPONENT

Annual action plan for Year 3 of the Health System Strengthening Component		Cumulative total for current FY	Balance for current FY
Line of action	BUDGET CFA F		
Sub-Component A: Management and health systems at regional and district levels			
Job descriptions of RHMT and DHMT members available in 10 regions	720 000	-	720 000
Consultation frameworks (Health-TFP-Local government unit and other health sector stakeholders) are functional in ten (10) regions	3 000 000	340 000	2 660 000
Stakeholders at medical regions and health districts are trained on governance and leadership in ten (10) regions	36 456 500	6 080 160	30 376 340
ORCAP tool is effectively utilized in all intervention regions	14 640 000	9 419 945	5 220 055
Support provided to ten (10) medical regions for the development of AWP	78 649 000	44 748 364	33 900 636
Annual joint portfolio reviews are held in all focus regions	25 789 000	9 838 394	15 950 606
The training guide on administrative and financial management as well as the accounting software for regional and district teams are adapted	44 678 200	14 163 515	30 514 685
Annual financial reports are prepared by the medical region and districts in 3 regions (Kolda, Thies and Kaolack)	-	-	-

DF implementation letters are signed with six (6) medical regions	19 810 190	122 043 905	(102 233 715)
Evaluation of the PBF pilot project is conducted	22 045 600	25 905 045	(3 859 445)
PBF extension strategy is adopted by the MOH	8 463 000	255 000	8 208 000
PBF mechanisms are implemented in at least twenty (20) health districts with contributions from financing sources other than USAID	149 759 000	136 083 103	13 675 897
The financing mechanism of the PBF extension phase is institutionalized	62 500 000	31 343 649	31 156 351
Payments owing to PBF project beneficiaries are made on time	320 000 000	97 144 346	222 855 654
<b>TOTAL SUB-COMPONENT A: Management and health system at regional and district levels</b>	<b>786 510 490</b>	<b>497 365 426</b>	<b>289 145 064</b>
<b>Sub-Component B: Social financing mechanisms</b>			
A UHC institutional support framework is established	18 500 000	18 621 041	(121 041)
The National healthcare solidarity fund/CAPSU is functional	3 000 000	-	3 000 000
Approximately fifty (50) MHOs at least receive subsidies for the expansion of their benefits packages through the national solidarity fund for healthcare or any other equivalent subsidization system	1 000 000	3 299 444	(2 299 444)
MHOs are operational in all local government units in nine (9) focus departments	139 603 000	204 365 094	(64 762 094)

A risk-pooling mechanism is developed to share large risks and ensure professional management of MHOs in each of the ten (10) focus departments	13 116 150	15 030 050	(1 913 900)
Partnerships are established between MHOs and micro-finance institutions in focus departments	2 500 000	-	2 500 000
MHOs and MHO networks in the entire intervention zone of the Component are functional	23 303 000	26 314 450	(3 011 450)
PLWHA support project is extended in three (3) regions	19 150 000	5 117 470	14 032 530
Health insurance, through MHOs, is effectively provided to vulnerable groups in at least forty (40) MHOs	8 973 000	3 247 090	5 725 910
<b>TOTAL SUB-COMPONENT B: Social financing mechanisms</b>	<b>229 145 150</b>	<b>275 994 639</b>	<b>(46 849 489)</b>
<b>Sub-component C: National level health policies and systems</b>			
At least one (1) policy initiative for health system strengthening is supported	40 300 000	57 704 641	(17 404 641)
Implementation of the community health policy is supported	11 000 000	7 378 880	3 621 120
A PNA strategic development plan is prepared and implemented	70 000 000	51 979 004	18 020 996
At least one (1) policy initiative in the maternal and newborn health, family planning, child health, malaria, HIV/AIDS and tuberculosis areas is supported	73 500 000	41 729 568	31 770 432
Regional health sector MTEFs are established in 10 regions	32 000 000	-	32 000 000

The 2014-2016 health sector MTEF is prepared within the required time-limit	7 950 000	3 739 000	4 211 000
The performance report of the 2013 health sector MTEF is delivered within the required time-limit	4 350 000	11 232 400	(6 882 400)
The 2015 draft budget based on allocation criteria defined by DAGE/MOH is prepared	-	4 464 803	(4 464 803)
The annual financial report of DAGE is prepared within the required time-limit	1 500 000	9 435 386	(7 935 386)
<b>TOTAL SUB-COMPONENT C: National level health policies and systems</b>	<b>240 600 000</b>	<b>187 663 682</b>	<b>52 936 318</b>
<b>Activity area D: Coordination</b>			
The Health Program's Steering Committee meetings are held as scheduled	1 250 000	1 282 000	(32 000)
Four technical group reports are prepared and validated	735 000	-	735 000
At least two inter-agency technical group reports are effectively applied by USAID implementing agencies	2 940 000	-	2 940 000
Action plan of the Component is developed and monitored	28 223 300	18 462 215	9 761 085
Periodic reports are prepared (quarterly reports and annual report)	6 769 600	1 970 251	4 799 349
Four (4) success stories are produced	3 800 000	140 000	3 660 000
<b>TOTAL ACTIVITY AREA D: COORDINATION</b>	<b>43 717 900</b>	<b>21 854 466</b>	<b>21 863 434</b>
<b>Total Action Plan</b>	<b>1 299 973 540</b>	<b>982 878 213</b>	<b>317 095 327</b>



**USAID**  
FROM THE AMERICAN PEOPLE



**MINISTÈRE DE LA SANTÉ ET  
DE L'ACTION SOCIALE**

# Results-Based Financing in Senegal: What Have We Learned so Far?

Presented by: Dr. Ndack Wadji Ly and Dr. Laurel Hatt, Abt Associates

September 2014

## Context: Urgent Need to Improve Health Outcomes in Senegal

- Weak health indicators
- Limited and poorly motivated health personnel, especially in remote rural areas
- Slow and weak health information system compromising the decision-making process
- Achieving health-related MDGs is a priority for the Government of Senegal



## Results-based Financing (RBF): Incentivizing Health Workers to Provide Effective and Quality Services

- Program led by the Government of Senegal with USAID support
- Implemented in **108 health facilities** (health posts and health centers) and **7 district health offices** in 2 regions, 2012-2013
- Seeking to:
  - Motivate health workers
  - Improve the **quality** of care
  - Improve health **outcomes**
  - Strengthen the **capacity** of district health teams
- **Financial incentives** provided for achieving maternal, newborn, child health and disease targets
- **Targets** are determined based on baseline performance in each facility
- **Quality of care** scores are used to modify incentive payments
- 75% of payments directly distributed to health staff; 25% invested in the health facility

## Research Questions

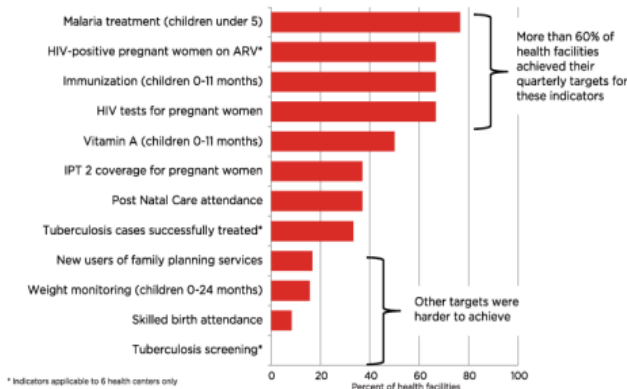
- How well have health facilities performed against RBF targets?
- How are health facilities responding to the RBF incentives?
- What are the successes and challenges in the implementation of the RBF pilot in Senegal so far?

## Methods

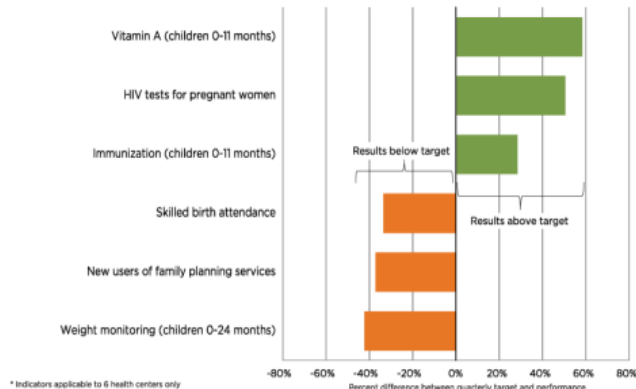
- A mixed methods approach:
  - **Quantitative:** Program monitoring data analysis
  - **Qualitative:** 40 semi-structured interviews with selected health workers and stakeholders

## Preliminary Results

### Percentage of Health Facilities Who Met or Exceeded Their Q3 2013 Targets, by Indicator



### Comparing Performance to RBF Targets in Q3 2013, for Selected Indicators



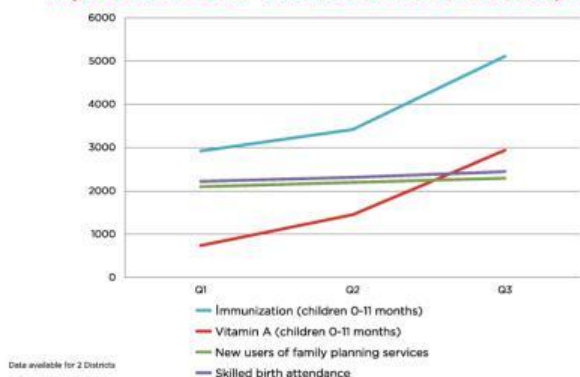
## Improvement Over Time in Selected Indicators, 2013

100.0 7

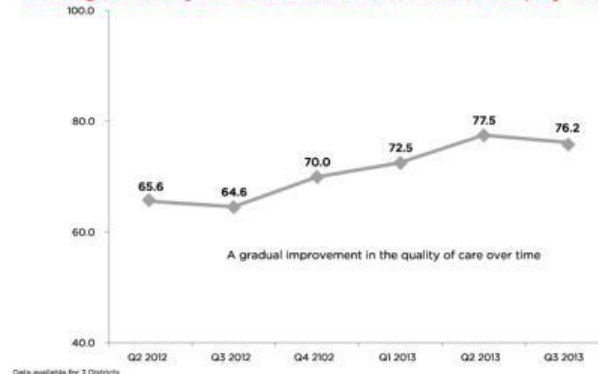
## Average Quality of Care Score of Health Posts, by Quarter

100.0 7

## Improvement Over Time in Selected Indicators, 2013



## Average Quality of Care Score of Health Posts, by Quarter



### What Is Working Well? Comments from health workers

#### • Better work environment:

- Marked improvement in conditions of health facilities (hygiene, supplies, and drug availability)
- Better division of labor and roles
- Improved communication among facility staff

*“What I’ve mostly noticed is (better) communication, work sharing, the fact that everyone knows what to do”*

(Health Post in Kaffrine)

#### • Increased motivation and creativity:

- Clear and specific goals motivating health workers to devise strategies to meet them
- Work recognition

*“At our district level meetings and seminars, we now discuss best practices and exchange strategies to reach RBF targets”*

(Health Post in Kolda)

#### • Increased community involvement in facility spending and management

### Strategies and Initiatives Employed by Health Workers to Improve Performance

#### • Increased involvement and capacity building of community health workers

- Redistribution of incentive payments to better compensate community health workers (health post in Kaffrine)

#### • Increased direct outreach to community

- Use of ambulance radio to call and invite mothers to vaccinate their children (health post in Kaffrine)
- Outreach to traditional healers for early referral of malaria cases among children (health post in Kolda)
- Outreach to and counseling of grandmothers and mothers-in-law on importance of facility-based deliveries, and of husbands on the benefits of family planning (health post in Kolda)



- Early planning of drug requests to avoid disruptions
- Recruitment of personnel

### Some Difficulties Identified by Health Workers

#### • Major delays in contract signatures and incentive payments:

- Demotivates health workers
- Threatens credibility of program

#### • Some indicators are less amenable to change:

- *Geographical and transportation barriers:* difficult access to health facilities for assisted deliveries
- *Human resource shortages:* lack of qualified personnel (e.g. midwives)
- *Cultural and religious barriers:* sensitivities to family planning use

#### • Insufficient training on RBF forms and procedures and lack of clarity on indicator definitions and calculation methods

#### • Lack of feedback to health facilities on performance, payments, disbursements



### Conclusions

#### A Promising Program with Tangible Results... Yet Some Critical Threats to Overcome

- Notable improvements in some health indicators and the quality of care
- Increased motivation among health workers
- Improved work and facility conditions
- Urgent need to address barriers that threaten the long-term success of the RBF program:
  - **Implementation challenges:** delays, feedback procedures, capacity of health workers
  - **Structural and staffing challenges** beyond the control of the health facilities; lack of measures to support facilities

### Acknowledgements

**Funding:** Ministère de la Santé et de l'Action Sociale (MSAS) and United States Agency for International Development (USAID)

**Program implementation:** Programme National du Financement Basé sur les Résultats (PNFBR); Renforcement du Système de Santé (R2S) project, Abt Associates, and Broad Branch Associates

**Research and data collection:** Centre de Recherche pour le Développement Humain (CRDH); Abt Associates, and Interview respondents



www.abtassociates.com